PROBLEMS WITH IMMIGRATION DETAINEE MEDICAL CARE

HEARING

BEFORE THE

SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW

OF THE

COMMITTEE ON THE JUDICIARY HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

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PROBLEMS WITH IMMIGRATION DETAINEE MEDICAL CARE

WEDNESDAY, JUNE 4, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP,
REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW
COMMITTEE ON THE JUDICIARY,
Washington, DC.

The Subcommittee met, pursuant to notice, at 2:05 p.m., in Room 2141, Rayburn House Office Building, the Honorable Zoe Lofgren (Chairwoman of the Subcommittee) presiding.

Present: Representatives Lofgren, Conyers, Gutierrez, Waters, Sánchez, Davis, Ellison, King, Goodlatte, and Lungren.

Also Present: Representative Smith.

Staff Present: David Shahoulian, Majority Counsel; Andrés Jimenez, Majority Professional Staff Member; George Fishman, Minority Counsel.

Ms. LOFGREN. This hearing of the Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law will come to order.

Without objection, the Chair is authorized to call a recess of the hearing at any time.

I would like to welcome the Subcommittee Members, our witnesses, and members of the public to the Subcommittee's hearing on problems with immigration detainee medical care. This Committee held a hearing on this subject on October 4, exactly 8 months ago. At that hearing we examined serious concerns with the provision of medical care at immigration detention facilities across the country. News reports of deaths and the deficient care that may have led to those deaths triggered that hearing. Unfortunately, here we are again.

As was the case 8 months ago, a string of recent news reports has severely shaken our confidence in the health care system used by ICE. The reports recount story after story of detainees who received inadequate care or no care at all, and they speak of suffering and death.

But this time those stories are not just reports; *The Washington Post* and 60 Minutes support those stories with internal Government documents and what appear to be many interviews with Government whistleblowers who have uncovered severe problems and desperately want to see them fixed. Some of the witnesses today will deny that these problems exist, but I believe these claims are

belied by Government officials who have reached out to the press and to us and by the documents that support their claims.

The efforts of those whistleblowers tell me something, that there are people within our Government who really care about the medical and mental health care provided at ICE facilities. But their stories and documents also say something else: That their pleas and warnings have gone largely unheeded for far too long.

Documents tell us that employees widely complained of severe staffing shortages of medical personnel. ICE tells us they are addressing these shortages now, but the documents indicate they ignored these warnings for years, failing to adequately address these shortages even as they ramped up enforcement and brought detention beds on line.

Documents tell us that employees complained of certain policies that appear to be in violation of ICE's detention standards. For some time at the San Pedro facility, for example, the clinical director prohibited medical staff from doing any lab work for detainees no matter what their condition until they had been detained for more than 30 days. As indicated by an internal DHS document, this policy may have played a role in the death of a detainee with HIV who was denied medication during her first month in detention.

Documents show that ICE's policy may be designed to deny care and save money rather than to provide care and save lives. Last October, Francisco Castaneda testified before our Committee concerning the medical care he received, or I should say failed to receive, during his detention. He is now dead. A quick review of his medical records shows that several on-site physicians recommended biopsy to rule out cancer, but it also shows that these requests were repeatedly denied over a 10-month period by managed care coordinators here in D.C.

Some might say this is just one case and does not signify anything. I disagree. When several doctors say that someone needs a simple biopsy, but this is denied not once, not twice, but repeatedly over 10 months by off-site bureaucrats, something is fundamentally wrong. No matter how it happened, there is no question that the system failed Mr. Castaneda over and over again. He paid with his life, and now the Government is on the verge of paying millions in a lawsuit pursued by his family.

In any event, that necessary treatment is repeatedly delayed or denied by ICE is supported by many other documents. There are letters and affidavits from prison wardens expressing profound exasperation with the denials of care.

And one document, which I can't even begin to reconcile with humane treatments, lists the amount of money ICE saved by denying requests for treatment. Such requests which were all submitted by on-site medical personnel were for such things as tuberculosis, pneumonia, bone fractures, head trauma, chest pain and other serious complaints. How an off-site bureaucrat can deny a request to treat tuberculosis or a bone fracture, I just don't know, but the document makes it seem as if ICE is proud of that fact.

Putting aside the inhumanity of denying necessary health care, the $1.3 million savings that ICE brags about in this document is

going to pale in comparison to the money that DHS will have to pay when courts begin to rule against it, as they already have.

With the large increase of detainees in ICE custody, it is incumbent upon this Congress to ensure that ICE is properly executing its responsibility of providing safe and humane treatment. I hope that today's hearing will help us begin to find solutions to what appears to be a very serious problem.

[The prepared statement of Ms. Lofgren follows:]

PREPARED STATEMENT OF THE HONORABLE ZOE LOFGREN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA, AND CHAIRWOMAN, SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW

This committee already held a hearing on this subject on October 4, 2007—exactly 8 months ago. At that hearing, we examined serious concerns with the provision of medical care at immigration detention facilities across the country. News reports of deaths—and the deficient care that may have led to those deaths—triggered that hearing.

Unfortunately, here we are again. As was the case eight months ago, a string of recent news reports has severely shaken our confidence in the health care system used by ICE. The reports recount story after story of detainees who received inadequate care, or no care at all. And they speak of suffering and death.

But this time, those stories are not just reports. The Washington Post and 60 Minutes support their stories with internal government documents and what appear to be many interviews with government whistleblowers who have uncovered severe problems and desperately want to see them fixed.

Some of the witnesses today will deny that these problems exist. But I believe these claims are belied by the numbers of government officials who have reached out to the press—and to us—and by the documents that support their claims.

The efforts of those whistleblowers tell me something—that there are people within our government who really care about the medical and mental health care provided at ICE facilities. But their stories and documents also say something else—that their pleas and warnings have gone largely unheeded for far too long.

Documents tell us that employees widely complained of severe staffing shortages of medical personnel. ICE tells us that they are addressing these shortages now. But the documents indicate they ignored these warnings for years, failing to adequately address such shortages even as they ramped up enforcement and brought detention beds on line.

Documents tell us that employees complained of certain policies that appear to be in violation of ICE's Detention Standards. For some time at the San Pedro facility, for example, the clinical director prohibited medical staff from doing any lab work for detainees—no matter what their condition—until they had been detained for more than 30 days. As indicated by an internal DIHS document, this policy may have played a role in the death of a detainee with HIV who was denied medication during her first month in detention.

Documents show that ICE's policies may be designed to deny care and save money rather than to provide care and save lives. Last October, Francisco Castaneda testified before our committee concerning the medical care he received, or failed to receive, during his detention. He is now dead. A quick review of his medical records shows that several on-site physicians recommended biopsy to rule out cancer. But it also shows that these requests were repeatedly denied, over a 10-month period, by managed care coordinators here in DC.

Some might say that this is just one case and does not signify anything. I disagree. When several doctors say that someone needs a simple biopsy, but this is denied not once, not twice, but repeatedly over 10 months by off-site bureaucrats, something is fundamentally wrong. No matter how this happened, there is no question the system failed Mr. Castaneda over and over again. He paid with his life, and now the government is on the verge of paying millions in a lawsuit pursued by his family.

In any event, that necessary treatment is repeatedly delayed or denied by ICE is supported by many other documents. There are letters and affidavits from prison wardens expressing profound exasperation with delays and denials of necessary care. And one document, which I can't even begin to reconcile with humane treatment, lists the amount of money ICE saved by denying requests for treatment. Such requests, which were all submitted by on-site medical personnel, were for such

things as tuberculosis, pneumonia, bone fractures, head trauma, chest pain and other serious complaints. How an off-site bureaucrat can deny a request to treat tuberculosis or a bone fracture, I don't know. But the document makes it seem as if ICE is proud of the fact.

Putting aside the inhumanity of denying necessary health care, the $1.3 million savings ICE brags about in this document will pale in comparison to the money DHS will have to pay when courts begin to rule against it—as they already have.

With the large increase of detainees in ICE custody, it is incumbent upon this Congress to ensure that ICE is properly executing its responsibility of providing safe and humane treatment. I hope that today's hearing will help us begin to find solutions to what appears to be a very serious problem.

Ms. LOFGREN. I now recognize our Ranking Minority Member Steve King for his opening statement.

Mr. KING. Thank you, Madam Chair.

This Subcommittee just had a hearing on the topic of immigration detainee medical care 8 months ago, and I am not sure that the recent media blitz alleging poor medical care in a few isolated instances warrants a second hearing.

The risk of being murdered in some U.S. cities is higher than the risk of dying in an immigration detention facility. That means people on the streets of America are not as safe as some of the people that are incarcerated under ICE. For example—and these numbers are significantly lower than other data I have seen. For example, 2005 FBI statistics show in the statistical metropolitan area encompassing the city of Houston, 712.6 residents per 100,000 were victims of violent crime, and 9.1 residents per 100,000 were murdered or victims of homicide. That is Houston. In Houston alone there are 334 people murdered on the streets.

In the statistical metropolitan area including Los Angeles, 575.5 per 100,000 were victims of violent crime; 8.8 out of every 100,000 were victims of murder. In Los Angeles alone there were 489 people murdered in 2005.

Some other examples would be the recent shootings in Washington, D.C. For example, my legislative counsel's neighborhood had four murders in a single 24-hour period right in the same neighborhood.

And in the Chicago shootings that we know about, 32 shootings over a weekend, at one time the death count was 6, and then it went to 12 or 13 in a single weekend. And we are here having a hearing about people incarcerated by ICE and getting medical care that is addressing their chronic illnesses as well that they come with. But during that same period of time, 2005, there were 6.8 deaths per 100,000 immigration detainees, many of whom were unhealthy when they arrived, and that is in ICE facilities. The number has dropped in subsequent years, and the data is getting stronger.

I would submit that the constituents of the Members of this Committee would be better served if our focus was on the high risk of being murdered and violently victimized on the streets of their own cities and own communities rather than focusing on a media event that doesn't have the data to back up the necessity for this hearing.

In any event, I am happy to use this opportunity to congratulate Ms. Myers for taking a lead role in reinvigorating ICE's worksite enforcement efforts, and that includes Iowa, and I thank you. All of us concerned about the impact of illegal immigration on Amer-

ican workers are grateful for your efforts. The death rate in our immigration detention facilities are low and dropping despite the fact that 25 percent of the detainee population already had a chronic illness such as hypertension, diabetes, tuberculosis, asthma, HIV/AIDS and seizure disorders when they came into ICE custody because they come from places where they don't get health care. That is why they are carrying chronic illnesses with them. This is the best and sometimes the first medical care that they have been exposed to in their lifetime.

This is a fundamental difference between criminal incarceration and immigration detention. Prison inmates who have been sentenced to incarceration cannot choose when they are released. They are detained in order to provide punishment and rehabilitation to safeguard the community, and to deter other criminals.

The medical care provided by the Bureau of Prisons ensures that inmates are not prevented from serving their full sentences, which average 9 years, because of illness. However, illegal immigrants and illegal aliens are in detention an average of only 37½ days, and they hold the keys to their own cells because immigration detainees can simply agree to their own deportations.

Why should the American taxpayer be liable for providing Rolls Royce-quality medical care for aliens who are doing everything in their power to stay detained and therefore avoid deportation? ICE should not have to make up for a lifetime of poor medical care during this brief period of detention. Once they enter the ICE detention system, most immigration detainees are getting by far the best medical care they have had in their entire lives. It has cost the Federal taxpayers more than $360 million to provide such care since ICE was created 5 years ago, $100 million in the last fiscal year alone.

But let's not forget that the full cost to American taxpayers for the health care of illegal immigrants is far more than the cost incurred by ICE detention. The majority of illegal aliens do not have health insurance. As a result, hospitals in the southwest border counties of Texas, New Mexico, Arizona and California alone incur a cost of $190 million for uncompensated emergency medical treatment to illegal aliens.

The California Hospital Association worries that care for illegal aliens could tip some hospitals into bankruptcy; and, in fact, some have closed. The medical crisis caused by uninsured illegal immigrants clogging our emergency rooms and seeking free medical care is also compromising our citizens' accessibility to emergency health care. On top of all of these costs, it appears that some want to give detained illegal immigrants a blank check written on the account of the American taxpayer.

Legislation introduced by Chair Lofgren seems to require American taxpayers to pay medical bills for immigration detainees even after they have been released or removed to their home country. That is not the taxpayer's responsibility.

We need to make decisions in this Committee and in this Congress based upon data, not anecdotes, and to allege the inhumanity of denying necessary health care I don't think can be substantiated, and I don't agree with that statement, and I look forward to the

hearing. I look forward to the testimony of the witnesses. Thank you, Madam Chair.

[The revised and extended remarks of Mr. King follows:]

REVISED AND EXTENDED REMARKS OF THE HONORABLE STEVE KING, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA, AND RANKING MEMBER, SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW

Replace this text:

"For example, 2005 FBI statistics show that in the statistical metropolitan area encompassing the city of Houston, 712.6 residents per 100,000 were victims of violent crime and 9.1 residents per 100,000 were murdered or victims of homicide. In the city of Houston alone, there were 334 people murdered in 2005. In the statistical metropolitan area including Los Angeles, 575.5 per 100,000 residents were victims of violent crime—with 8.8 per 100,000 murders and homicides. In Los Angeles alone, there were 489 people murdered in 2005."

With the following paragraphs:

"For example, 13 homicides took place during one week of March this year in our nation's capitol, Washington DC. Not to be left behind, during a six-day period in April, Chicago suffered a shooting spree that left 12 dead. The 2005 U.S. Census Bureau statistics show that in Congressman Gutierrez's city of Chicago, there were 443 murders in 2005, or 15.6 deaths per 100,000. In the Chairman of the House Committee on the Judiciary John Conyers' city of Detroit, Michigan 2,361 residents per 100,000 were victims of violent crime and there were 1,858 murders in 2005, or 41.4 deaths per 100,000. In Congresswomen Zoe Lofgren, Maxine Waters and Linda Sánchez' state of California, Los Angeles had 1,628 murders in 2005, or 12.6 deaths per 100,000 and 821 per 100,000 residents were victims of violent crime. In Congresswoman Sheila Jackson Lee's city of Houston, Texas 1,173 residents per 100,000 were victims of violent crime and there were 860 murders, or 16.3 deaths per 100,000.

While 15 detainees died while under ICE custody in 2005, and while the Members who represent the four cities I mentioned demanded we retreat from Iraq due to American loss of life, and while 676 brave American soldiers gave their lives in a just cause, 4,789 individuals were murdered on the streets of just four cities without a word of concern from the Members who represent many of the victims and their families. These statistics support the fact that residents of Chicago, Detroit, Los Angeles or Houston would be safer in an ICE detention facility than walking on the streets of these cities. Constituents of the Majority members of the House Judiciary Committee would be better served if our focus was on the high risk that they will be murdered or victimized by violent criminals in their own communities."

Ms. LOFGREN. I would just note that on the bill I have introduced, it does not require provision of care after release, but I would be happy to discuss that off agenda.

I would now recognize the Chairman of the full Committee Mr. John Conyers.

Mr. CONYERS. Thank you, Chairman Lofgren and Members. This is, I think, important.

I want to agree to this extent with the opening statement of my friend Steve King. Maybe we are able, Steve, to do both things. We have to deal with the crime problem that you've reported in your statistics, which are accurate, and perhaps with this problem of how people who are brought into our custody are treated afterward. I want my statement to be included in the record.

I just wanted to welcome the head of ICE, whom I hadn't met before, Ms. Myers. I wanted to welcome her, and I wanted to talk with the Committee about this sudden breakout of mass arrests, the largest in history, in Iowa last month, 300 undocumented peo-

ple arrested, going all over, raids everywhere, mass round-ups. Have we had a hearing on that yet?

Ms. LOFGREN. No, Mr. Chairman, but if you are suggesting, we can.

Mr. CONYERS. I would like to talk with Steve King about it first. I yield to the gentleman.

Mr. KING. I thank the Chairman. I think that would be a constructive thing to do, and I would be very interested in joining together for a request for a hearing.

Mr. CONYERS. Thank you very much.

There is some kind of evenhandedness that ought to be required. Employers bring in all these people. They know who is illegal or undocumented or not. I think we have to start rounding some of them up, too. But that's a subject for another time.

I figure it is pretty reasonable that we look at this subject matter again. As my friend pointed out, it was 8 months ago we did this, but things keep happening, and let's stipulate that a lot of people that have come here illegally need medical assistance, but the question is what do we do about it?

And I will just close because I have been talking to some of my friends here in the Congress and on the Committee about universal health care, and a kind of similar issue that Steve raised comes up. Well, if you have universal health care, why include immigrants? Well, because they are going to spread disease and make it tough on all of us who might someday have universal health care.

So these are the interesting questions that surround this hearing. You have brought together a great panel of witnesses, and I thank you for allowing my opening comments.

[The prepared statement of Mr. Conyers follows:]

PREPARED STATEMENT OF THE HONORABLE JOHN CONYERS, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN, AND CHAIRMAN, COMMITTEE ON THE JUDICIARY

A very disturbing pattern appears to be developing at the Department of Homeland Security. First, there are revelations about medical abuses, problematic raids, misplaced emergency priorities, and inappropriate costumes. And, then—only after a formal Congressional inquiry—the Department either denies there's a problem or announces plans to correct it.

Today, we are going to continue our efforts to address one of these recurrent problems, namely, the broken medical system in our Nation's detention facilities. As many of you will recall, this Subcommittee held a hearing on this issue last year where we heard the heartbreaking testimony of a woman who stood helpless as her sister died behind bars because ICE would not give her access to her medications.

But the reports of grossly inadequate detainee medical care continue to surface. This callous disregard for detainee's medical conditions must stop.

Accordingly, I want Assistant Secretary Julie Myers, and the other witnesses to respond to three specific concerns.

First, I want to hear what concrete steps DHS has taken since our hearing last October, and what concrete steps are will be undertaken going forward. In the eight months since our last hearing, it appears little has changed. That is why I am a proud cosponsor of Chairwoman Lofgren's bill, the Detainee Basic Medical Care Act of 2008, which will address this problem.

Second, I want hear what the DHS Inspector General has done and will do to investigate the deaths in custody, not just on a case-by-case basis, but across the board as well.

Third, I want to hear DHS's response to reports about a recent raid at a meatpacking plant in Iowa.

In that raid, immigrants were penned up in a fairground and subjected to a new version of assembly-line justice, in which criminal charges and limited access to counsel replaced the normal administrative immigration charges.

I want Ms. Myers and the other witnesses to tell us today what ICE is doing to address health care and humanitarian concerns when these mass raids are being undertaken. What kind of health care was provided in Iowa? Was anyone sent back home without receiving any treatment? Is this just an isolated incident or can we expect this to become the Department's "standard operating procedure."

DHS should ensure that basic standards of life, safety, health care, due process, and Constitutional rights are maintained, not just in response to public scandal.

Ms. LOFGREN. I now recognize the distinguished Ranking Member of the full Committee, the gentlemen from Texas, Mr. Smith.

Mr. SMITH. Madam Chairman, recent news reports detail cases of severe injury and even death in DHS detention facilities. Each of the instances as reported is heartbreaking to family members and of concern to all of us. However, we should not rush to judgment based on one-sided media accounts about the reported deficiencies in health care received by a few illegal immigrant detainees. Congress has a responsibility to rely on the facts in order to determine if there is a serious problem with the medical treatment provided to these detainees.

Since 2004, 71 individuals out of over 1 million detained have died while in DHS custody. Many of these individuals enter detention facilities with prior medical conditions that can cause injury or death.

About one-quarter of all immigration detainees are diagnosed as having chronic illnesses when they enter the detention facility. Many of these individuals are being diagnosed for the first time, and many of them have infectious diseases such as tuberculosis, which poses a serious health threat to Americans. Immigrants, at over 12 percent of the population now, account for more than half of all tuberculosis cases in the U.S. That means that immigrants are over four times more likely to carry that contagious disease than native-born Americans.

Last year, ICE spent nearly $100 million on detention immigration health care, double the funding level that existed just 5 years ago. Medical facilities at all ICE-managed and -contracted detention centers are required to meet or exceed normal accreditation standards. Immigration detainees are provided extensive free health care far beyond that available to many of the American taxpayers who pay for the detainees' health care.

In a recent series, *The Washington Post* alleged that there is "a hidden world of flawed medical judgments, faulty administrative practices, neglectful guards, ill-trained technicians, sloppy record-keeping, lost medical files and dangerous staff shortages." Yet according to ICE, the *Post* reporters made no requests to tour a single ICE detention facility.

A July 2007 Government Accountability Office report on alien detention standards found no systemic problems in health care delivery or any pattern of noncompliance with applicable standards.

Substantiated allegations of improper medical care to immigration detainees should be fully investigated. If it is determined in a particular case that a detainee was denied appropriate treatment, was not properly monitored or received negligent care, then corrective measures must be taken.

Congress should be clear that it is not the responsibility of ICE, or the American taxpayer, to pay for or ensure the medical care of aliens after they are removed from our country. Nor is it the re-

sponsibility of ICE, or the American taxpayer, to keep aliens in detention solely for the purpose of providing them care.

Today ICE and the Division of Immigration Health Services have an opportunity to present their side of the story.

Holding hearings on this issue is important, but we must have reasonable and realistic standards. Medical care is not always perfect regardless of whether it is administered in a detention center prison or even the emergency room of a hospital.

I thank you, Madam Chair, and I yield back the balance of my time.

Ms. LOFGREN. Thank you, Mr. Smith.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF THE HONORABLE LAMAR SMITH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS, AND RANKING MEMBER, COMMITTEE ON THE JUDICIARY

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Holding hearings on this issue is important. But we must have reasonable and realistic standards. Medical care is not always perfect, regardless of whether it is administered in a detention center, prison or even the emergency room of a hospital.

Ms. LOFGREN. In the interest of proceeding to our witnesses, and mindful of the schedule, I ask other Members to submit their state-

ments for the record. Without objection, all opening statements will be placed into the record.

[The prepared statement of Ms. Jackson Lee follows:]

PREPARED STATEMENT OF THE HONORABLE SHEILA JACKSON LEE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS, AND MEMBER, SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY, AND INTERNATIONAL LAW

Madam Chair, thank you for your leadership in convening today's very important hearing concerning the problems with immigration detainee medical care. I would also like to thank the ranking member, the Honorable Steve King. This hearing will explore recent reports about inadequate medical care for immigrant detainees and deaths while in custody.

The hearing will also examine the quality of medical and mental health care provided in detention facilities under ICE's jurisdiction. The Subcommittee will study ICE's medical and mental health care standards and procedures, and it will specifically look into the deaths of the growing number of immigration detainees that have died during or as a result of ICE custody, seeking to resolve the extent to which policies, procedures, or practice caused these deaths. Finally, the Subcommittee will seek recommendations to address any potential problems.

The Bureau of Immigration and Customs Enforcement (ICE) within the Department of Homeland Security (DHS) is responsible for the arrest, detention, and removal of deportable non-citizens. In 2006, ICE detained nearly 300,000 men, women, and children—most of whom had no criminal history. This was three times the amount of immigration detainees held by ICE in 2001, when less than 100,000 were detained. ICE holds its immigration detainees in one of over 300 detention facilities across the country. A small percentage of these detainees are housed in 8 ICE-owned and operated service processing centers (SPCs), including the Krome SPC in Miami, the Florence SPC in Arizona, and the Port Isabel SPC in Texas. ICE also houses a small percentage of its detainees in 6 contract detention facilities (CDFs), which are operated by private contractors specifically for ICE. The majority of detainees are held with general population inmates in about 300 federal, state, and local jails and other facilities, which operate through intergovernmental service agreements (IGSAs) with ICE. In addition to these adult detention facilities, ICE contracts for the operation of 19 juvenile and 3 family detention facilities.

In carrying out its detention and removal responsibilities, ICE is charged with ensuring that conditions are safe and humane in all detention facilities used to hold immigration detainees. These responsibilities include the provision of adequate medical and mental health care to detainees.

On October 4, 2007, the Subcommittee held a hearing on medical care in detention facilities after a New York Times article uncovered that at least 62 people had died in ICE custody between 2004 and 2007. Since that hearing, major media outlets have reported additional deaths and have released documents indicating that some of these deaths were the result of deficient medical care. A four-part series recently released by the Washington Post raises similar concerns about the medical and mental health care system at ICE detention facilities. This series, founded on internal ICE documents and interviews with detention facility employees, asserts severe staffing shortages of medical personnel, long and routine delays in the provision of medical treatment, frequent denials of necessary medication for chronic illnesses, and a system geared to deny care rather than provide it.

In July 2007, the U.S. Government Accountability Office (GAO) issued a report detailing additional problems with detention conditions. The GAO report noted that when off-site medical care for detainees appeared necessary, ICE determined whether to authorize such care in conjunction with a DIHS Managed Care Coordinator (MCC). According to the report, officials at some detention facilities reported difficulty caring for detainees who required off-site medical and mental health care because they were unable to get authorization to provide that specialty care.

In addition, numerous media outlets—including the *New York Times, The Washington Post,* and *60 Minutes*—have reported stories suggesting a lack of proper medical care for detainees. On June 13, 2007, the Washington Post reported on a number of cases involving immigration detainees who allegedly received inadequate medical care. That same day, a class action lawsuit was filed on behalf of all immigration detainees at the San Diego Correctional Facility (SDCF). The lawsuit, *Woods v. Myers,* No. 07-cv-1078 (S.D. Cal.) charged ICE, DIHS, and the Corrections Corporation of America, Inc. with failing to provide adequate medical and mental health care to SDCF detainees. According to the complaint, the 11 named plaintiffs

suffered from mental illness, chronic health conditions, and serious injuries that had not been appropriately treated while in ICE custody.

Later in June 2007, the New York Times reported that at least 62 immigrants had died in ICE custody since 2004. In July, the editorial board of the Miami Herald called upon Congress to investigate this issue and require ICE to publicly report each death that occurs in custody and to adopt legally binding healthcare standards.

Since the Subcommittee hearing in October, numerous reports from major media outlets have raised additional concerns with the medical and mental health care provided in immigration detention centers. On May 5, 2008, the New York Times revealed a list of 66 individuals who had died in ICE custody, reporting details on several of the deaths that raised serious concerns about the quality of the medical care they received.

This article was followed by an extensive, four-part series on detainee medical care by the Washington Post in May. According to the Washington Post, this series of articles was based on an extensive investigation involving the review of thousand of internal ICE documents and interviews with numerous ICE and DIHS personnel. The articles—as well as the internal ICE documents produced along with the articles—reveal serious staffing shortages of medical personnel, regular delays in the provision of medical treatment, and frequent denials of necessary treatment. In the first part in the series, System of Neglect, the Washington Post summarized their investigation as follows:

> The most vulnerable detainees, the physically sick and the mentally ill, are sometimes denied the proper treatment to which they are entitled by law and regulation. They are locked in a world of slow care, poor care and no care, with panic and coverups among employees watching it happen, according to a Post investigation.
>
> The investigation found a hidden world of flawed medical judgments, faulty administrative practices, neglectful guards, ill-trained technicians, sloppy record-keeping, lost medical files and dangerous staff shortages. It is also a world increasingly run by high-priced private contractors. There is evidence that infectious diseases, including tuberculosis and chicken pox, are spreading inside the centers.

By statute and regulation, the U.S. Public Health Service (PHS) may provide medical, surgical, psychiatric, and dental care to immigration detainees around the country. However, PHS provides on-site health care to only a small percentage of ICE detainees. PHS officers provide on-site medical and mental health care at ICE-run service processing centers (SPCs) and several of the contract detention facilities (CDFs) and intergovernmental service agreement facilities (IGSAs). At all other facilities, including virtually all state and county jails operating under IGSAs with ICE, on-site medical care is provided either by the county or a private company that owns or operates the facility, or by private, for-profit companies that specialize in correctional health care.

ICE holds its immigration detainees in one of over 300 detention facilities across the country. A small percentage of these detainees are housed in 8 ICE-owned and operated service processing centers (SPCs), including the Krome SPC in Miami, the Florence SPC in Arizona, and the Port Isabel SPC in Texas. ICE also houses a small percentage of its detainees in 6 contract detention facilities (CDFs), which are operated by private contractors specifically for ICE.

I look forward to hearing from today's witnesses. I truly hope that we can understand the problems with immigration detainee medical care and that we can also develop some solutions. I look forward to the testimony of today's witnesses. Thank you, and I yield the balance of my time.

Ms. LOFGREN. We have two distinguished panels of witnesses here today to help us consider the important issues before us. Seated on our first panel is Ms. Julie Myers, Assistant Secretary for U.S. Immigration and Customs Enforcement (ICE). Previously she served as Assistant Secretary for Export Enforcement at the Department of Commerce, Chief of Staff for the Criminal Division at the Department of Justice, and Deputy Assistant Secretary for Money Laundering and Financial Crimes at the Treasury Department.

Before entering Government service Ms. Myers was an associate at Mayer, Brown and Platt in Chicago, and she earned a bachelor's

degree at Baylor University and a law degree from Cornell University.

Next we have Dr. Philip Farabaugh, the new Acting Director of the Division of Immigration Health Services, or DIHS, which we understand was recently moved from Health and Human Services to the Department of Homeland Security. Prior to his position as Acting Director, Dr. Farabaugh was the clinical director at the Tacoma detention facility in Tacoma, Washington.

And the final witness on our first panel is Mr. Richard Stana, Director of Homeland Security and Justice Issues for the U.S. Government Accountability Office. During his 32-year career with the GAO, he has directed reviews in a wide variety of complex military and domestic issues. Most recently he has managed GAO's work relating to immigration and border security issues. He is a graduate of Cornell University and Harvard University's JFK School of Government. He also earned a master's degree from Kent State University.

Given the gravity of the issues we are discussing today and the key roles you all play, we would appreciate you taking an oath before you begin your testimony. Would each of you please stand and raise your right hand.

[Witnesses sworn.]

Ms. LOFGREN. The clerk will note that all three witnesses have agreed to the oath.

Your written statement will be made a part of the record in its entirety. We would ask now that you summarize your testimony in about 5 minutes. The little machine on the desk will flash a yellow light when you have 1 minute left, and when the red light goes on, we would ask you to conclude the testimony so we have time for our questions.

Ms. Myers, we will begin with you.

TESTIMONY OF JULIE MYERS, ASSISTANT SECRETARY, IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE), U.S. DEPARTMENT OF HOMELAND SECURITY

Ms. MYERS. Thank you very much.

Good afternoon, Chairwoman Lofgren and distinguished Members of the Subcommittee. I appreciate the opportunity to appear before you today.

Chairwoman Lofgren, you're right, people in Government do care. The men and women of ICE care. The men and women of the DIHS care, and we work every day to ensure that those in our custody are treated in accordance with the ICE detention standards.

As you know, ICE was formed in 2003 with the broad mission that includes immigration and customs enforcement and management of the detention and removal processes for apprehended aliens. Indeed, with such an important mission, we had to look and see could we have additional oversight, additional oversight not only for medical care, but really for all of our detention, knowing that there are a large number of aliens in our custody.

I think we have worked very hard over the past couple of years to see where there are places where we can improve detention oversight. To that end, I think the GAO has been very helpful, the IG, as well as Congress and NGOs, in giving us ideas and suggestions

on how we can make sure that everyone in our custody is treated in accordance with the ICE detention standard.

We have done a number of things. Just giving a few highlights of things that we have done for detention oversight overall, including but not limited to medical care, in February 2007 we established the Detention Field Inspection Group, and that is a group that is an independent arm that reports to the Office of Professional Responsibility. They can go out and do an independent inspection of a detention facility to see if they are meeting up to the medical standard as well as all other standards in the ICE detention standard. Before that there was no such independent group.

In addition, we looked at our overall reviews of facilities, and we recognized that previously under the old INS, they used detention and removal officers who tried to do a good job, but they were detention and removal officers who actually did the annual compliance inspections. We changed that. We contracted with outside groups to do annual reviews of our facilities in order to make sure that we were getting the best information, and if there were deficiencies, they could be corrected. These deficiencies would include anything we needed to work on with respect to medical oversight.

In addition, we have hired quality assurance specialists at 40 of our largest facilities. Their only job is to make sure that ICE is complying with the ICE detention standards. And we have also published our first Semiannual Report on Compliance with the ICE National Detention Standards.

We created the first National Detainee Handbook, and we have undertaken a comprehensive review of the current National Detention Standards to see whether or not they could be improved. We think they could be, so we are working to make them more performance-based, working with the NGOs, the IGs, DHS, CRCL and so on.

Turning specifically to detainee health care and oversight, let me begin with some context. ICE spent almost $100 million on detainee health care last fiscal year, double the funding of just 5 years ago. And this doesn't even include the funding providing for routine health care at IGSAs. During that same period, the number of detention beds managed by ICE has grown by approximately 30 percent, and since ICE was established, nearly 1.5 million individuals have passed through our custody. And although the ICE detainee population has increased by more than 30 percent since 2004, the actual number of deaths in ICE detention has declined from 29 in 2004 to 7 for the last calendar year, and there have been no suicides in the last 15 months.

But there is still more work to do. ICE law enforcement officers are not medical professionals, so we have historically relied on the independent medical judgment of the experts, the Public Health Service and DIHS.

By way of background, all detainees are required to receive an initial health screening within the first 12 hours and a physical examination within 14 days. And as Representative King noted, last year nearly 34 percent of detainees were diagnosed with a chronic condition.

Despite all of this, we recognize that there is need to take additional steps. Among them was the need to strengthen the suicide

prevention process. The reality is since 2003, suicides have accounted for 18 percent of the 74 deaths of detainees in our custody. Even one preventable death is too many, so in the last 2 years ICE instituted an extensive suicide prevention program, and we have not had a single suicide in the last 15 months.

We also are looking at the TAR process, and I believe there is room for improvement on the appeals of TARs, and so we are working with the Office of Health Affairs to see how we can strengthen the TARs process and provide for more oversight by independent individuals, as well as have the detainees have more of a role in that.

We are also working with the DHS Office of Health Affairs to improve operations at DIHS. Already we have reduced the staffing issues from 30 percent vacancies down to 18. In addition, we have asked the Office of Health Affairs to assess all of DIHS's procedures to determine whether or not there are additional things we can do to strengthen oversight for those who are in our custody.

The final thing we have done is respond to suggestions that we need to have more transparency in the reporting of deaths. And so we have talked with the DOJ, and we are going to begin reporting voluntarily pursuant to the Deaths in Custody Reporting Act so that the Bureau of Justice Statistics will have our information, and they can access it as appropriate.

In closing, I want to say we are committed to working with you, outside groups and others to improve our processes and ensure that those in our custody are well cared for. Thank you.

Ms. LOFGREN. Thank you.

[The prepared statement of Ms. Myers follows:]

PREPARED STATEMENT OF JULIE L. MYERS

U.S. Immigration and Customs Enforcement

STATEMENT

OF

JULIE L. MYERS
ASSISTANT SECRETARY
U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
DEPARTMENT OF HOMELAND SECURITY

REGARDING A HEARING ON

"PROBLEMS WITH IMMIGRATION DETAINEE MEDICAL CARE"

BEFORE THE

HOUSE COMMITTEE ON THE JUDICIARY
SUBCOMMITTE ON IMMIGRATION, CITIZENSHIP, REFUGEES,
BORDER SECURITY, AND INTERNATIONAL LAW SUBCOMMITTEE

Wednesday, June 4, 2008 @ 2:00 pm
2141 Rayburn House Office Building

Good afternoon, Chairwoman Lofgren and distinguished Members of the Subcommittee. I appreciate the opportunity to appear before you to discuss the quality medical care and safe and humane treatment that Department of Homeland Security's (DHS) U.S. Immigration and Customs Enforcement (ICE) provides to immigration detainees as well as some of the initiatives we are undertaking to further improve care.

ICE was formed in March 2003 with a broad mission that includes immigration and customs enforcement and management of the detention and removal processes for apprehended aliens. In carrying out this mission, one of our highest priorities is to provide quality care to those individuals in our custody. As such, ICE remains committed to ensuring the safety and well being of the hundreds of thousands of individuals who come through our detention facilities each year.

OVERSIGHT IMPROVEMENTS ACROSS ALL ASPECTS OF DETENTION

Indeed, with such an important mandate, improved oversight of a variety of ICE functions has been a cornerstone of my approach. In the past two years, ICE has made significant strides in improving oversight and updating the decades-old practices inherited from the former Immigration and Naturalization Service (INS).

For example, in February 2007, ICE established the Detention Facilities Inspection Group. This group resides within the Office of Professional Responsibility (essentially our "internal affairs function) independent of the Office of Detention and Removal Operations (DRO) which carries out the detention and removal functions on a day-to-day basis. The DFIG has the responsibility for reviewing and validating detention inspections and ensuring the consistent application of agency standards to make certain that corrective actions are taken.

ICE has also contracted with independent experts to place full-time quality assurance professionals at each of our 40 largest facilities and to arrange for rotational visits to our

smaller facilities. Additionally, ICE has contracted with outside experts to conduct annual facility inspections, which were previously performed by ICE personnel.

To improve transparency, ICE released its first Semiannual Report on Compliance with ICE National Detention Standards January - June 2007, which tracks detention facilities' compliance with national detention standards. This first-of-its-kind report will be issued semi-annually and is posted on the front page of ICE's website. It is my hope that by publishing this information, we will help enhance transparency and general understanding of our detention system by detailing the results of more than 175 facility compliance inspections.

To improve communication and operational consistency with our Intergovernmental Service Agreement (IGSA) partners, ICE is in the process of standardizing the IGSA contracts which were individualized agreements with our 300-plus local government partners. This will allow ICE to more effectively manage these contracts to ensure that our partners are adhering to our National Detention Standards.

ICE has also, for the first time, developed a national detainee handbook. Available in both Spanish and English, the detainee handbook provides standardized information on topics such as rights and responsibilities, grievance procedures, suicide prevention, telephone access, consular notifications, visitation, mail, meals, recreation, religious services, and more.

Beyond merely complying with our standards, we have also undertaken a complete review of the existing National Detention Standards. The existing standards were developed in 2000 by the former INS in consultation with outside stakeholders. Though they've served us well, we believe we can further ensure we meet our obligations by updating policies and procedures to performance based standards that reflect past experiences, agency practices, and protocols. ICE is vigorously working to transform the current detention standards into a performance-based format, consistent with the approach used by the American Correctional Association. In doing so, ICE has solicited

feedback and is considering recommendations from Non-Governmental Organizations, the DHS Office of Inspector General, and other groups such as the United Nations High Commission on Refugees. We have worked closely with the DHS Office for Civil Rights and Civil Liberties to consider these recommendations and develop improved standards. The new standards are expected to be completed later this year.

TRENDS

Turning now more specifically to detainee health care and oversight, let me begin with some context: ICE spent almost $100 million on detainee health care last fiscal year, double the funding of just five years ago. During that same period, the number of detention beds managed by ICE has grown by approximately 30 percent. Since ICE was established, more than 1 million individuals have passed through our custody. Though the ICE detainee population has increased by more than 30 percent since 2004, the actual number of deaths in ICE detention has declined from 29 in 2004 to 7 last year. There have also been no suicides in the last 15 months.

DETAINEE HEALTHCARE TODAY

As a unit within ICE, DIHS serves as the provider of medical and mental health care for detainees housed in DIHS-staffed detention facilities and manages certain healthcare functions provided by medical professionals at non-DIHS-staffed detention facilities. But there is still much work to do. It's important to recognize that ICE law enforcement officers are not medical professionals, so we have historically relied on the independent medical judgment of the professionals within DIHS, which include doctors, clinical support professionals and support staff (some of whom are detailed to DHS from the U.S Public Health Service (PHS)), contractors, and general schedule employees. We will continue to work closely with DHS Office of Health Affairs and PHS to evaluate and improve processes and practices.

All detainees are required to receive an initial health screening within 12 hours of arrival at the detention facility in order to determine the appropriate medical, mental health, and/or dental treatment that may be needed. At that time, ICE provides immediate attention to detainees who present a danger or an imminent risk to themselves or others, including those who have infectious diseases, uncontrolled mental health disorders, or conditions that would deteriorate if not addressed immediately by medical personnel. In addition to the initial health care screening, ICE policy also requires that detainees receive a health appraisal and physical examination within 14 days of arrival to identify medical conditions that require monitoring or treatment.

Last year, 34 percent of detainees screened were diagnosed with, and treated for, preexisting chronic conditions, such as hypertension and diabetes. Many of these detainees would not have identified their medical ailment or received medical care and treatment were it not for the comprehensive health screening they received.

In addition to the initial screening and medical evaluation, the ICE standards on Medical Care require that all detainees, regardless of classification, have access to sick call, which provides detainees the opportunity to request health care services provided by a physician or other qualified medical officer in a clinical setting. Procedures are in place to ensure that all requests for health care services are received by the health service provider in a timely manner. During screenings, evaluations, and visits, a medical professional assesses the detainee's health and treatment requirements and arranges any medications, consultations, or other services needed. The sick call process allows detainees to access non-emergency medical services, and all facilities are required to have regularly scheduled times when medical personnel will be available to see detainees who have requested services.

Medical care provided at each detention facility also includes access to necessary prescription medications. Prescriptions written for detainees by the health service provider are filled either by an on-site pharmacy or by a local community pharmacy. If a prescription medication is not readily available and a detainee has a supply of the

medication needed or can obtain a supply of the medication from a family member, that medication may be used as long as the facility's medical staff can verify the validity of the medication to ensure it is appropriate for the detainee to take and to prevent contraband from entering a facility. In FY 2007, DIHS alone wrote more than 210,000 prescriptions.

ICE detainees also have access to mental health care provided by qualified professionals and receive a mental health screening within 12 hours of admission. Detainees who request mental health services or are identified upon intake screening as needing further evaluation are referred to an appropriate mental health professional, usually a clinical psychologist or social worker.

DIHS psychologists and social workers provide 23 different types of psychological services that are therapeutic in nature. These services include not just supportive therapy or counseling, but psychological assessment, psychoeducation, crisis intervention services, suicide risk assessment, suicide watch follow-up services to ensure safety, case management services and consultation with other medical professionals. Psychiatric services are also available to ICE detainees. Psychiatrists provide psychiatric evaluations, follow-up medication management, and they consult with the psychologists, social workers, and primary care providers when appropriate.

Detainees who require medical care beyond what can be provided at their detention facility have access to specialized care by submitting Treatment Authorization Requests (TARs) to the DIHS Managed Care Program. Specialized procedures provided through the TAR process may include heart surgery, cancer treatment, dialysis, and a variety of general surgical procedures. In an effort to even further enhance the TAR process, ICE is working to improve the appeal process for the relatively small number of TARs that are disapproved. I will talk a bit more about that shortly, but once this process has been developed, the ICE Detainee Handbook and orientation process will be updated to provide a complete description of the TAR process.

The ICE Medical Program has an established covered benefits package that delineates the health care services, medical products, and treatment options available to all detainees in ICE custody. The ICE covered services package emphasizes that benefits are provided for conditions that pose an imminent threat to life, limb, hearing or sight, rather than to elective or non-emergency conditions. Medical conditions that the local treating physicians believe would cause suffering or deterioration of a detainee's health are also assessed and evaluated through the DIHS Managed Care Program. The DIHS Managed Care Program has a network of more than 500 hospitals, 3000 physicians, and 1300 other health care facilities that provide a wide range of medical care and services.

As the number of individuals in ICE custody has risen in recent years -from approximately 227,000 detainees in FY 03 to more than 300,000 in FY 07- demand for health care and medical services has also grown significantly.

In FY 03, DIHS staff had 256,843 detainee visits, including 9,349 dental; 8,950 mental health; 14,566 short stay unit visits: and 47,372 sick calls. In FY 07 DIHS showed a total caseload of 711,719 health/medical visits, including 16,885 dental; 23,224 mental health; 56,823 short stay unit visits; and 97,620 sick calls.

STRENGTHENED HEALTHCARE OVERSIGHT

Despite these many accomplishments, ICE has recognized the need for a variety of both medical and administrative oversight revisions.

Among them was the need to strengthen the suicide prevention process. The reality is that since 2003, suicides have accounted for 18 percent of the 74 deaths of detainees in custody. Even one preventable death is too many. Accordingly, over the past two years, ICE instituted an extensive suicide prevention program. The goal of the program is to ensure that all individuals at our detention facilities remain both safe and healthy. Suicide is always a risk at any detention facility and anyone suffering from mental illness is at

increased risk. ICE has continuously taken a proactive approach to mitigating these risks. I am pleased to report ICE has not had a single suicide in over 15 months.

Here are some of the steps we have taken to address this ongoing challenge.

ICE's National Detention Standards require that all staff working with detainees in detention facilities be trained to recognize signs and situations potentially indicating a suicide risk. Staff must act to prevent suicides with appropriate sensitivity, supervision, and referrals. Any clinically suicidal detainee must receive preventive supervision and treatment.

On October 17, 2006, ICE DRO issued a memorandum to all Field Office Directors reiterating the requirements of the Suicide Prevention and Intervention detention standard and directing them to verify compliance with the standard for all detention facilities used to house ICE detainees within their respective geographic areas of responsibility.

Furthermore, all Field Office Directors verified that their staff are receiving annual training, that facilities have appropriate medical coverage to provide for detainees' mental health needs, and that policy and procedures are in place to ensure prompt reporting of suicides and suicide attempts.

Each of these initiatives demonstrates our firm and continuing commitment to protecting the well-being of those in our detention facilities and ensuring that those who may be at risk for suicide immediately receive all appropriate care and counseling.

Additionally, ICE is working with the DHS Office of Health Affairs (OHA) to improve operations at DIHS. Already numerous improvements have been implemented, and others are underway, including the selection of a new Acting DIHS director, streamlining the hiring process to address staff shortages and moving towards an improved electronic medical records system.

I want to expand a bit on just one of these improvements: ICE has asked OHA and outside medical experts to assess all of DIHS' procedures to determine what changes we can make to ensure the best quality care for those in our custody.

ICE is also working with the DHS OHA on developing an enhanced appeal process for the very small number of TAR's that are initially denied. I believe this is an area where we can improve. Currently, there are a variety of reasons that TARs may not be approved such as: the person for whom treatment is being sought may not in fact be in ICE custody; the TAR does not include enough information to determine medical necessity; there are alternate acceptable treatment options at the facility; or the request was not submitted in a timely fashion and the treatment has already be delivered. Any TAR that is denied due to a lack of timeliness by a managed care coordinator is forwarded to the Managed Care Coordinator Branch Chief for reconsideration.

DIHS has a formal appeals process for denied TARs. The request can be resubmitted for reconsideration to the MCC. If unsuccessful it can be appealed to the DIHS Medical Director. If that is still unsuccessful, a final appeal can be submitted to the Managed Care Review Committee (MCRC), which is comprised of the DIHS Medical Director, appropriate medical, dental, or mental health consultants, and MCCs. Decisions of the MCRC will be made in writing within 3 working days of the appeal and faxed back to the requestor.

ICE, DIHS, and OHA are working to develop a more independent appeal body outside of DIHS and ICE. One possibility under consideration is to have OHA perform this final level of appeal function. This will allow an alien to have even greater say in his or her own medical care.

ICE and DIHS will also begin working with OHA on a general stand-alone medical care grievance process that would be separate from the standard facility grievance process. As soon as we complete these initiatives, the National Detainee Handbook and local orientation procedures will be updated to reflect these changes.

CONCLUSION

In closing, I would like to say on behalf of each and every ICE employee that we remain committed to ensuring the safety and well being of the hundreds of thousands of individuals who come through our detention facilities each year. Please also know that I have had the distinct pleasure to meet with a number of the fine men and women at DIHS who provide healthcare services to ICE detainees. I can tell you that they share my dedication to providing high quality health care to all of their patients and to working with the Department of Homeland Security – with ICE and our colleagues at the Office of Health Affairs – to continue to improve our administrative processes and medical oversight. As in the past, as we continue to improve we will seek your input and guidance, as well as that of NGOs, the IG and others.

I would like to thank you, Ms. Chairwoman and Members of the Subcommittee, for the opportunity to appear before you today. In developing this testimony, I've consulted with experts on these matters and offer testimony and answers to your questions based upon this information. I will gladly answer your questions.

Ms. LOFGREN. Dr. Farabaugh, we would be pleased to hear from you.

TESTIMONY OF PHILIP FARABAUGH, ACTING DIRECTOR, DIVISION OF IMMIGRATION HEALTH SERVICES, IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE), U.S. DEPARTMENT OF HOMELAND SECURITY

Dr. FARABAUGH. Good afternoon, Chairwoman Lofgren and Members of the Subcommittee, and thank you for allowing me to appear before you today.

The Division of Immigration Health Services provides or arranges for health care and public health services in support of immigration law enforcement. As a unit within U.S. Immigration and Customs Enforcement, ICE, DIHS serves as the provider of medical and mental health care for detainees housed in DIHS-staffed detention facilities.

DIHS oversees the financial authorization and payment for offsite specialty and emergency care for all detainees in ICE custody, whether in DIHS or Intergovernmental Service Agreement facilities.

DIHS comprises medical professionals and support personnel detailed from the U.S. Public Health Service, General Schedule employees and contracted medical staffing services. The PHS is granted the authority to provide and arrange this care by virtue of section 322 of the Public Health Service Act "Care and Treatment of Persons Under Quarantine and Certain Other Persons."

Each individual who comes through detention facilities receives an initial medical screening within 12 hours of their arrival into custody. Those remaining in ICE supervision at least 14 days receive a comprehensive physical examination. Many of these detainees initially learn of a medical ailment or receive medical care and treatment for the first time through this comprehensive screening. Each individual receives specific treatment, as medically necessary according to their illness. In fiscal year 2007, of the 184,448 screenings, approximately 34 percent, or 63,000 individuals, were identified as having chronic conditions, most diagnosed with hypertension or diabetes.

To address the needs of the growing number of detainees, DIHS mental health staff have provided over 31,000 patient encounters for psychological services since April 2007. These services include psychological assessments and followups, individual psychotherapy sessions, initial psychiatric evaluations, psychiatric medication and medication management followup, acute mental health hospitalizations, suicide risk assessment and follow-up. This list is not all-inclusive, and applies only to those detainees in facilities where DIHS mental health officers and staff are assigned.

Individuals who have acute or chronic health care needs are referred to a primary care provider for evaluation and medical treatment. Those found to have an infectious disease are placed in the appropriate health care setting and receive treatment for their condition.

Patients are treated in accordance with nationally recognized standards and guidelines. This care may be given off site or on site, as appropriate for the individual patient's clinical condition. Exam-

ples of such care include imaging studies like X-rays, CT scans, and MRIs; surgery for broken bones, heart conditions, gallstones, and appendicitis; and specialty consultation with urology for a bladder disorder, infectious disease for a patient with HIV, and gastroenterology for evaluation of stomach ulcers. Pregnant detainees are referred to community obstetricians to ensure the appropriate prenatal care is delivered.

The DIHS medical staff and epidemiology branch monitor tuberculosis cases to ensure continuity of care, whether the detainee is to be released from custody into the United States or returned to his or her country of origin. Between January 1, 2007, and May 31, 2008, ICE coordinated the repatriations to home countries of 156 individuals with active or suspected active tuberculosis. DIHS seeks to minimize stress to public health domestically and globally and prevent transmission of drug-resistant and multidrug-resistant tuberculosis.

Each DIHS-staffed clinic has a written plan for delivery of 24-hour emergency health care or immediate outside medical attention. All facilities have arrangements with nearby medical facilities or health care providers for health care not provided within the facility. These arrangements require appropriate custodial officers to transport and remain with the detainee for the duration of any off-site treatment or hospital admission. When an ICE detainee is hospitalized, the hospital assumes medical decisionmaking authority, including the patient's drug regimen, lab tests, et cetera.

Each DIHS clinic has a mechanism that allows detainees to request health care services provided by a physician or other qualified medical officer in a clinical setting. Detainees, especially those who are illiterate or do not speak English, can receive assistance in filling out the request slip to access health care providers.

Each detainee who is identified with a chronic care issue is treated and educated on self-care needs, and appropriate treatment and follow-up is coordinated.

DIHS maintains accreditation from three nationally recognized accrediting bodies to ensure the quality of health care meets industry standards. This includes the American Correctional Association, the National Commission on Correctional Health Care, and the Joint Commission on Accreditation of Health Care Organizations, as well as the ICE National Detention Standards to evaluate the care provided to our detainees.

All DIHS health care providers who care for detainees are required to be licensed and credentialed under the same guidelines as those serving the U.S. Bureau of Prisons and in other Federal or community facilities, and we have an ongoing credentials-monitoring program to identify and correct any noted deficiencies.

Thank you once again for allowing me to provide testimony before your Committee today, and I am happy to answer any questions you may have.

Ms. LOFGREN. Thank you.

[The prepared statement of Dr. Farabaugh follows:]

PREPARED STATEMENT OF PHILIP FARABAUGH

U.S. Immigration and Customs Enforcement

STATEMENT

OF

PHILIP FARABAUGH, MD
COMMANDER, U.S. PUBLIC HEALTH SERVICE

ACTING DIRECTOR
DIVISION OF IMMIGRATION HEALTH SERVICES

U.S. IMMIGRATION AND CUSTOMS ENFORCEMENT
DEPARTMENT OF HOMELAND SECURITY

REGARDING A HEARING ON

"PROBLEMS WITH IMMIGRATION DETAINEE MEDICAL CARE"

BEFORE THE

HOUSE COMMITTEE ON THE JUDICIARY
SUBCOMMITTE ON IMMIGRATION, CITIZENSHIP, REFUGEES,
BORDER SECURITY, AND INTERNATIONAL LAW SUBCOMMITTEE

Wednesday, June 4, 2008 @ 2:00 pm
2141 Rayburn House Office Building

Good afternoon, Chairwoman Lofgren and members of the Subcommittee, and thank you for allowing me to appear before you today.

The Division of Immigration Health Services (DIHS), provides or arranges for health care and public health services in support of immigration law enforcement. As a unit within U.S. Immigration and Customs Enforcement (ICE), DIHS serves as the provider of medical and mental health care for detainees housed in DIHS-staffed detention facilities. DIHS oversees the financial authorization and payment for off-site specialty and emergency care for all detainees in ICE custody, whether in DIHS or Intergovernmental Service Agreement (IGSA) facilities. DIHS comprises medical professionals and support personnel detailed from the U.S. Public Health Service (PHS), General Schedule (GS) employees and contracted medical staffing services. The PHS is granted the authority to provide and arrange this care by virtue of section 322 of the Public Health Service Act (42 U.S.C. 249) "*Care and Treatment of Persons under Quarantine and Certain Other Persons.*"

Each individual who comes through detention facilities receives an initial medical screening within 12 hours of their arrival into custody. Those remaining in ICE supervision at least 14 days receive a comprehensive physical examination. Many of these detainees initially learn of a medical ailment or receive medical care and treatment for the first time through this comprehensive screening. Each individual receives specific treatment, as medically necessary according to their illness. In FY2007, of the 184,448

screenings, 34% (63,628 individuals) were identified as having chronic conditions, most diagnosed with hypertension or diabetes.

To address the needs of the growing number of detainees, the psychologists and social workers of DIHS have provided 31,697 patient encounters for psychological services. Since April of 2007, psychologists and social workers have provided the following services; Psychological Assessments, Psychological Follow-Up Appointments, Individual Psychotherapy Sessions, Initial Psychiatric Evaluations, Psychiatric Medication Mgmt Follow-Up, Acute MH Hospitalizations (does not include Columbia Care), Suicide Risk Assessments, and Suicide Watch Follow Up Appointments. This list is not all-inclusive and applies only to those detainees in facilities where DIHS Mental Health officers and staff are assigned. Crises Intervention Services, consultations to Special Housing Unit Intakes, Special Housing Unit Follow-Up Appointments and other services provided to detainees are not listed in the above tally. Approximately 82 % of the services were direct patient contact.

Individuals who have acute or chronic health care needs are referred to a primary care provider for evaluation and medical treatment. Those found to have an infectious disease are placed in the appropriate health care setting and receive treatment for their condition.

Patients are treated in accordance with nationally recognized standards and guidelines. This care may be given on- or off-site, as appropriate for the individual patient's clinical condition. Examples of such care include imaging studies like x-rays, CT scans, and

MRI's; surgery for broken bones, heart conditions, gall stones, and appendicitis; and specialty consultation with urology for a bladder disorder, infectious disease for a patient with HIV, and gastroenterology for evaluation of stomach ulcers. Pregnant detainees are referred to community obstetricians to ensure that appropriate prenatal care is delivered.

The DIHS medical staff and the Epidemiology Branch monitor tuberculosis (TB) cases to ensure continuity of care, whether the detainee is to be released from custody into the United States or returned to his or her country of origin. Between January 1, 2007 and May 31, 2008, ICE coordinated the repatriations to home countries of 156 individuals with active or suspected active tuberculosis. DIHS seeks to minimize threats to public health domestically and globally and prevent transmission of drug-resistant and multi-drug-resistant tuberculosis.

Each DIHS staffed clinic has a written plan for delivery of 24-hour emergency health care or immediate outside medical attention. All facilities have arrangements with nearby medical facilities or health care providers for health care not provided within the facility. These arrangements require appropriate custodial officers to transport and remain with the detainee for the duration of any off-site treatment or hospital admission. When an ICE detainee is hospitalized, the hospital assumes medical decision making authority, including the patient's drug regimen, lab tests, X-rays and treatments.

Each DIHS clinic has a mechanism that allows detainees to request health care services provided by a physician or other qualified medical officer in a clinical setting. Detainees,

especially those who are illiterate or do not speak English, can receive assistance in filling out the request slip to access a health care provider.

Each detainee who is identified with a chronic-care issue is treated and educated on self-care needs, and appropriate treatment and follow-up are coordinated.

DIHS maintains accreditation from three nationally-recognized accrediting bodies to ensure the quality of health care meets industry standards, which include the American Correctional Association (ACA), the National Commission on Correctional Health Care (NCCHC), the Joint Commission, as well as the ICE National Detention Standards to evaluate the care provided to detainees. All DIHS health care providers who care for detainees are required to be licensed and credentialed under the same guidelines as those serving the U.S. Bureau of Prisons and in other federal or community facilities, and we have an ongoing credentials monitoring program to identify and correct any noted deficiencies.

Thank you once again for allowing me to provide testimony before your committee today. I'm happy to answer any questions you have.

Ms. LOFGREN. We will turn to you now, Mr. Stana.

TESTIMONY OF RICHARD M. STANA, DIRECTOR, HOMELAND SECURITY AND JUSTICE ISSUES, GOVERNMENT ACCOUNTABILITY OFFICE

Mr. STANA. Thank you, Chairman Lofgren and Mr. King, for the invitation to testify at today's hearing on ICE's adherence to medical care standards in its detention facilities.

As you know, ICE maintains custody of a highly transient and diverse population, with individuals from many countries with varying medical conditions and security risks; and includes males, females and families of every age group. The care and treatment of aliens while in detention is a significant challenge to ICE, as concerns continue to be raised by Members of Congress and advocacy groups about the treatment of the growing number of aliens while in ICE's custody.

In response to a request from the House Judiciary and Homeland Security Committees, we reported last summer on ICE's adherence to its National Detention Standards to help ensure appropriate conditions of confinement.

Of the 38 standards, we selected 8 for examination based on discussions with UNHCR, the ABA and the OIG. These dealt with telephone access, medical care, hold room procedures, use of force, food services, recreation, access to legal materials, and detainee grievance procedures. Our report did not specifically examine the quality of medical care issues, as that was the subject of a separate request from this Committee.

I would like to discuss three main items that are germane to today's hearing. First, at the time of our visits, we observed instances of noncompliance with ICE's medical care standards at 3 of the 23 facilities we visited, but these instances did not show a pervasive or persistent pattern of noncompliance across the facilities like those we identified with the telephone system. Specifically, at the San Diego facility in California, an adult detention facility, ICE reviewers that we accompanied cited PHS staff for failing to administer the mandatory 14-day physical exam to approximately 260 detainees. At the Casa de San Juan Family Shelter in California, we found that the facility staff did not administer medical screenings immediately upon admission. And at the Cowlitz County Juvenile Detention Center in Washington State, we found that no medical screening was performed at admission, and first aid kits were not available as required.

Officials at some facilities told us that meeting the specialized medical and mental health needs of detainees was challenging. For example, officials at the York facility in Pennsylvania cited difficulties in obtaining ICE approval for a mammogram to evaluate a lump in a detainee's breast, and the facility ultimately paid for the medical service itself.

On the other hand, we observed instances where detainees were receiving specialized medical care, such as special breathing equipment for a detainee at the Krome facility in Florida where we were told that the detainee had sleep apnea. And a detainee at the Hampton Roads facility in Virginia received treatment from a kidney dialysis machine.

Second, ICE's own compliance inspections also showed noncompliance with medical standards. The most recently available annual inspection reports for 20 of the 23 detention facilities that we visited showed that ICE reviewers had identified a total of 59 deficiencies, 4 of which involved medical care. The Wakulla County Sheriff's Office in Florida had sick call request forms that were available only in English, whereas the population was largely Spanish-speaking. The Cowlitz County Juvenile Facility did not maintain alien medical records on site. The San Diego facility, in addition to the physical exam deficiency I just mentioned, failed to obtain informed consent from the detainee when prescribing psychiatric medication, and the Broward Transitional Center in Florida did not have medical staff on site to screen detainees arriving at 5 p.m. and did not have a properly locked medical cabinet.

I should also note, though, that we observed three ICE inspection teams reviewing facilities and found that one was very good, but the two others were less thorough.

My last point relates to grievance procedures and the grievances and complaints filed by detainees at the facilities on a range of issues including the lack of timely response for requests for medical treatment. We found that ICE grievance standards were not followed at 4 of the 23 facilities we visited, and noncompliance ranged from issues like not having the grievance procedures in the handbook that is handed out to the persons upon entry, not having a grievance log at all, and not recording all grievances in the log. But the primary mechanism for detainees to file external complaints is directly with the IG, either in writing or by phone using the OIG complaint hotline.

Our review of the approximately 750 detainee complaints in the OIG database showed that about 11 percent involved issues relating to medical care such as being denied access to specialized treatment. But in testing the phone system, we found that the OIG complaint hotline telephone number was blocked or otherwise restricted at 12 of the 23 facilities that we visited. So the number of reported allegations may not reflect all detainee complaints.

Many complaints sent to the OIG were referred to ICE's DRO for action, but we could not determine the number, nature or disposition of these cases because DRO's complaint database was not sufficiently reliable for audit purposes.

In closing, our work noted various deficiencies in compliance with ICE detention standards, but there was not a persistent or pervasive pattern regarding medical standards at the locations we visited. Importantly, it should be noted that our review did not examine quality of care issues or ICE decisionmaking on specific detainee medical cases. Nonetheless, our work showed the need for ICE to address a number of internal control weaknesses to help ensure that it is in a much better position to identify and address existing and potential deficiencies.

This concludes my oral statement, and I would be happy to answer any questions that the Subcommittee Members may have.

Ms. LOFGREN. Thank you.

[The prepared statement of Mr. Stana follows:]

PREPARED STATEMENT OF RICHARD M. STANA

United States Government Accountability Office

GAO

Testimony before the Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law, Committee on the Judiciary, House of Representatives

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ALIEN DETENTION STANDARDS

Observations on the Adherence to ICE's Medical Standards in Detention Facilities

Statement of Richard M. Stana
Director, Homeland Security and Justice Issues

GAO-08-869T

June 4, 2008

GAO
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Highlights

Highlights of GAO-08-869T, a testimony to the Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law, Committee on the Judiciary, House of Representatives

ALIEN DETENTION STANDARDS

Observations on the Adherence to ICE's Medical Standards in Detention Facilities

Why GAO Did This Study

In fiscal year 2007, Department of Homeland Security's (DHS) U.S. Immigration and Customs Enforcement (ICE) detained over 311,000 aliens, with an average daily population of over 30,000 and an average length of stay of about 37 days in one of approximately 300 facilities. The care and treatment of aliens while in detention is a significant challenge to ICE, as concerns continue to be raised by members of Congress and advocacy groups about the treatment of the growing number of aliens while in ICE's custody. This testimony focuses on (1) the extent to which 23 facilities complied with medical care standards, (2) deficiencies found during ICE's annual compliance inspection reviews, and (3) the types of complaints filed by alien detainees about detention conditions. This testimony is based on GAO's July 2007 report evaluating, among other things, the extent to which 23 facilities complied with aspects of eight of ICE's 38 National Detention Standards. This report did not address quality of care issues.

What GAO Recommends

While this testimony contains no new recommendations, GAO made recommendations to DHS to, among other things, establish improved internal control procedures to help ensure that detainee complaints are properly documented and their disposition recorded. DHS agreed with GAO's recommendations and is making progress implementing them.

To view the full product, including the scope and methodology, click on GAO-08-869T. For more information, contact Richard M. Stana at (202) 512-8777 or stanar@gao.gov.

What GAO Found

At the time of its visits, GAO observed instances of noncompliance with ICE's medical care standards at 3 of the 23 facilities visited. These instances related to staff not administering a mandatory 14-day physical exam to approximately 260 detainees, not administering medical screenings immediately upon admission, and first aid kits not being available as required. However, these instances did not show a pervasive or persistent pattern of noncompliance across all 23 facilities. Officials at some facilities told GAO that meeting the specialized medical and mental health needs of detainees had been challenging, citing difficulties they had experienced in obtaining ICE approval for outside nonroutine medical and mental health care. On the other hand, GAO observed instances where detainees were receiving specialized care at the facilities visited.

At the time of its study, GAO reviewed the most recently available ICE annual inspection reports for 20 of the 23 detention facilities that it visited; these reports showed that ICE reviewers had identified a total of 59 instances of noncompliance with National Detention Standards, 4 of which involved medical care. One facility had sick call request forms that were available only in English whereas the population was largely Spanish speaking. Another did not maintain alien medical records on-site. One facility's staff failed to obtain informed consent from the detainee when prescribing psychiatric medication. Finally, another facility did not have medical staff on-site to screen detainees arriving after 5 p.m. and did not have a properly locked medical cabinet. GAO did not determine whether these instances of noncompliance were subsequently corrected as required.

The types of grievances at the facilities GAO visited typically included the lack of timely response to requests for medical treatment, missing property, high commissary prices, poor food quality and insufficient food quantity, high telephone costs, problems with telephones, and questions concerning detention case management issues. ICE's detainee grievance standard states that facilities shall establish and implement procedures for informal and formal resolution of detainee grievances. Four of the 23 facilities GAO visited did not comply with all aspects of ICE's detainee grievance standards. For example, one facility did not properly log all grievances that GAO found in their facility files. Detainee complaints may also be filed with several governmental and nongovernmental organizations. The primary way for detainees to file complaints is to contact the DHS Office of Inspector General (OIG). About 11 percent of detainee complaints to the OIG between 2005 and 2006 involved medical treatment issues. However, we found that the OIG complaint hotline 1-800 number was blocked or otherwise restricted at 12 of the facilities we tested. OIG investigates the most serious complaints and refers the remainder to other DHS components. GAO could not determine the number of cases referred to ICE's Detention Removal Office and concluded that ICE's detainee compliant database was not sufficiently reliable.

Chairman Lofgren, Mr. King, and members of the Subcommittee:

Thank you for inviting me here today to discuss our observations on the adherence to medical standards in alien detention facilities. According to the Department of Homeland Security's (DHS) U.S. Immigration and Customs Enforcement (ICE) officials, they maintain custody of one of the most highly transient and diverse populations of any correctional or detention system in the world. In fiscal year 2007, ICE detained over 311,000 aliens, with an average daily population of over 30,000 and an average length of stay of about 37 days (50 percent stay 18 days or less). This diverse population includes individuals from different countries; with varying medical conditions and security risks (criminal and noncriminal); and includes males, females, and families of every age group.

The care and treatment of aliens while in detention is a significant challenge to ICE, as concerns continue to be raised by members of Congress and advocacy groups about the treatment of the growing number of aliens while in ICE's custody. ICE has 38 National Detention Standards to help ensure that alien detainees are housed under appropriate conditions of confinement. These standards relate to a range of detainee services, including medical services. ICE policy is to conduct annual compliance inspection reviews of all adult, juvenile, and family detention facilities to check compliance with these standards. In doing so, ICE inspection staff are to review each detention facility's compliance with about 300 factors that are related to these standards (e.g., whether under the medical care standard the facility established a policy and procedures for responding to a detainee hunger strike). In addition to being required to comply with ICE's National Detention Standards, some ICE detention facilities are accredited by The Joint Commission, the predominant standards-setting and accrediting body in health care, and the National Commission on Correctional Health Care (NCCHC), which offers a health services accreditation program to determine whether correctional institutions meet its standards in their provision of health services.

From May 2006 through May 2007 we conducted a review to determine the extent to which selected facilities complied with aspects of 8 of the 38 standards, whether similar deficiencies were disclosed by ICE's annual compliance inspection review process, and the nature and disposition of complaints filed by aliens in detention facilities. We selected these eight National Detention Standards to review on the basis of interviews with officials from the United Nations High Commissioner for Refugees (UNHCR), the American Bar Association, and DHS Office of the Inspector General (OIG). These eight standards we reviewed were telephone access,

medical care, hold room procedures, use of force, food services, recreation, access to legal materials, and detainee grievance procedures. During the course of our review we visited 23 detention facilities under ICE oversight—18 of 330 adult, 2 of 19 juvenile, and all 3 family detention facilities. Because we did not randomly select our detention facilities, the results of our field observations from these facilities cannot be generalized to the full universe of detention facilities nationwide. However, these observations provided us with an overview of compliance with detention standards at different sizes and types of facilities in various locations across the country. We reviewed policies, procedures, documents, and inspection and grievance reports pertaining to detainee conditions of confinement, and interviewed facility and ICE staff responsible for compliance with the eight standards that we reviewed. In addition, we interviewed some individual detainees concerning their treatment at detention facilities, particularly with respect to the eight standards, but did not independently assess the merits of detainee complaints.

My statement today is based on our results regarding medical care standards that we reported in July 2007[1] and addresses the extent to which the 23 facilities complied with ICE's medical care standards, deficiencies found during ICE's annual compliance inspections of these facilities, and the types of complaints filed by alien detainees about detention conditions. With respect to ICE medical care standards, we ascertained whether (1) a range of medical and mental health services specified in ICE's standards were available, (2) detainees received initial medical screening upon admission and a more complete physical exam within 14 days of admission,[2] (3) detainees had the opportunity to request medical services, (4) specialized medical and mental health services could be arranged, (5) procedures and facilities for suicide prevention were available, and (6) a plan for 24-hour emergency care was available. We did not systematically review individual detainee medical cases or ICE decisions on the type or extent of nonroutine treatment that is medically necessary, nor did we otherwise investigate quality of care.

[1]GAO, *Alien Detention Standards: Telephone Access Problems Were Pervasive at Detention Facilities; Other Deficiencies Did Not Show a Pattern of Noncompliance*, GAO-07-875 (Washington, D.C.: July 6, 2007).

[2] ICE standards state that detainees are to receive an initial medical screening immediately upon admission and a more complete medical assessment within 14 days. The policy also states that a health care specialist shall determine needed medical treatment.

Some Instances of Noncompliance with Medical Care Standards Occurred

At the time of our visits, we observed instances of noncompliance with ICE's medical care standards at 3 of the 23 facilities we visited. However, these instances did not show a pervasive or persistent pattern of noncompliance across the facilities like we those identified with the telephone system.[3] Detention facilities that we visited ranged from those with small clinics with contract staff to facilities with on-site medical staff, diagnostic equipment such as X-ray machines, and dental equipment. Medical service providers include general medical, dental, and mental health care providers that are licensed by state and local authorities. Some medical services are provided by the U.S. Public Health Service (PHS), while other medical service providers may work on a contractual basis.

At the San Diego Correctional Facility in California, an adult detention facility, ICE reviewers that we accompanied cited PHS staff for failing to administer the mandatory 14-day physical exam to approximately 260 detainees. PHS staff said the problem at San Diego was due to inadequate training on the medical records system and technical errors in the records system. At the Casa de San Juan Family Shelter in California, we found that the facility staff did not administer medical screenings immediately upon admission, as required in ICE medical care standards. At the Cowlitz County Juvenile Detention Center in Washington state, we found that no medical screening was performed at admission and first aid kits were not available, as required.

Officials at some facilities told us that meeting the specialized medical and mental health needs of detainees can be challenging. Some also cited difficulties they had experienced in obtaining ICE approval for outside nonroutine medical and mental health care as also presenting problems in caring for detainees. On the other hand, we observed instances where detainees were receiving specialized medical care at the facilities we visited. For example, at the Krome facility in Florida we observed one detainee sleeping with the assistance of special breathing equipment (C-

[3]The most persistent and pervasive problem we found was with the detention facility telephone systems. Many facilities used an ICE contractor-provided telephone system, known as the "pro bono telephone system," to satisfy the standard that requires the facilities to provide a means for detainees to make calls to certain entities at no charge to themselves or the recipient. At 16 of the 17 facilities we visited that used this system, we had significant problems making connections to consulates, pro bono legal providers, and the DHS OIG complaint hotline.

PAP machine) to address what we were told was a sleep apnea condition. At the Hampton Roads Regional jail in Virginia we observed a detainee receiving treatment from a kidney dialysis machine. Again, assessing the quality of care and ICE's decision—making process for approval of nonroutine medical procedures were outside the scope of our review.

ICE Compliance Inspections Also Show Some Instances of Noncompliance With Medical Standards

We reviewed the most recently available ICE annual inspection reports for 20 of the 23 detention facilities that we visited. With the exception of the San Diego facility in California, the reports covered a different time period than that of our review.[4] The 20 inspection reports showed that ICE reviewers had identified a total of 59 instances of noncompliance, 4 of which involved medical care. According to ICE policy, all adult, juvenile, and family detention facilities are required to be inspected at 12-month intervals to determine that they are in compliance with detention standards and to take corrective actions if necessary. As of November 30, 2006, according to ICE data, ICE had reviewed approximately 90 percent of detention facilities within the prescribed 12-month interval. Subsequent to each annual inspection, a compliance rating report is to be prepared and sent to the Director of the Office of Detention and Removal or his representative within 14 days. The Director of the Office of Detention and Removal has 21 days to transmit the report to the field office directors and affected suboffices. Facilities receive one of five final ratings in their compliance report—superior, good, acceptable, deficient, or at risk.[5] ICE officials reported that as of June 1, 2007, 16 facilities were rated "superior," 60 facilities were rated "good," 190 facilities were rated "acceptable," 4 facilities were rated "deficient," and no facilities were rated "at risk." ICE officials stated that this information reflects completed

[4] Our review was done from May 2006 to May 2007, whereas the ICE inspection reports were done at various times during 2004, 2005 and 2006.

[5] According to Detention Management Control Program policies and procedures, a superior rating means that the facility is performing all of its functions in an exceptional manner, has excellent internal controls, and exceeds expectations. A good rating means that a facility is performing all of its functions, and there are few deficient procedures, but internal controls are not limited by these deficiencies. An acceptable rating means that detention functions are being adequately performed. Although deficiencies may exist, they do not detract from the acceptable accomplishment of the vital functions. Deficient ratings mean that one or more detention functions are not being performed at an acceptable level. Internal controls are weak, thus allowing for serious deficiencies in one or more program areas. At-risk ratings mean the detention operations are impaired to the point that they are not presently accomplishing their overall mission. That is, internal controls are not sufficient to reasonably ensure acceptable performance can be expected in the future.

reviews, and some reviews are currently in process and pending completion. Therefore, ICE could not provide information on the most current ratings for some facilities.

Four inspection reports disclosed instances of noncompliance with medical care standards. The Wakulla County Sheriffs Office in Florida had sick call request forms that were available only in English whereas the population was largely Spanish speaking. The Cowlitz County Juvenile Detention Facility in Washington state did not maintain the alien juvenile medical records on-site. The San Diego Correctional facility staff, in addition to the deficiencies noted earlier in this statement, failed to obtain informed consent from the detainee when prescribing psychiatric medication. Finally, the Broward Transitional Center in Florida did not have medical staff on-site to screen detainees arriving after 5 p.m. and did not have a properly locked medical cabinet. We did not determine whether these deficiencies were subsequently addressed as required.

Alien Detainee Complaints Included Concerns About Medical Care

Our review of available grievance data obtained from facilities and discussions with facility management showed that the types of grievances at the facilities we visited typically included the lack of timely response to requests for medical treatment, missing property, high commissary prices, poor quality or insufficient quantity of food, high telephone costs, problems with telephones, and questions concerning detention case management issues. ICE's detainee grievance standard states that facilities shall establish and implement procedures for informal and formal resolution of detainee grievances. Four of the 23 facilities we visited did not comply with all aspects of ICE's detainee grievance standards. Specifically, Casa de San Juan Family Shelter in San Diego did not provide a handbook to those aliens in its facility, the Cowlitz County Juvenile Detention Center in Washington state did not include grievance procedures in its handbook, Wakulla County Sheriff's Office in Florida did not have a log, and the Elizabeth Detention Center in New Jersey did not record all grievances that we observed in their facility files.

The primary mechanism for detainees to file external complaints is directly with the OIG, either in writing or by phone using the DHS OIG complaint hotline. Detainees may also file complaints with the DHS Office for Civil Rights and Civil Liberties (CRCL), which has statutory responsibility for investigating complaints alleging violations of civil rights and civil liberties. In addition, detainees may file complaints through the Joint Intake Center (JIC), which is operated continuously by both ICE and U.S. Customs and Border Protection (CBP) personnel, and is responsible

for receiving, classifying, and routing all misconduct allegations involving ICE and CBP employees, including those pertaining to detainee treatment. ICE officials told us that if the JIC were to receive an allegation from a detainee, it would be referred to the OIG. OIG may investigate the complaint or refer it to CRCL or DHS components such as the ICE Office of Professional Responsibility (OPR) for review and possible action. In turn, CRCL or OPR may retain the complaint or refer it to other DHS offices, including ICE Office of Detention and Removal (DRO), for possible action. Further, detainees may also file complaints with nongovernmental organizations such as ABA and UNHCR. These external organizations said they generally forward detainee complaints to DHS components for review and possible action.

The following discussion highlights the detainee complaints related to medical care issues where such information is available. We did not independently assess the merits of detainee complaints.

- Of the approximately 1,700 detainee complaints in the OIG database that were filed in fiscal years 2003 through 2006, OIG investigated 173 and referred the others to other DHS components. Our review of approximately 750 detainee complaints in the OIG database from fiscal years 2005 through 2006 showed that about 11 percent involved issues relating to medical treatment, such as a detainees alleging that they were denied access to specialized medical care.[6]

- OPR stated that in fiscal years 2003 through 2006, they had received 409 allegations concerning the treatment of detainees. Seven of these allegations were found to be substantiated,[7] 26 unfounded,[8] and 65

[6]In connection with the persistent and pervasive telephone problems we found, the OIG complaint hotline telephone number was blocked or otherwise restricted at 12 of the 23 facilities that we visited. Therefore, while some detainees at these facilities may have filed written complaints with the OIG, the number of reported allegations may not reflect the universe of detainee complaints.

[7]OPR defines "substantiated allegation" as an allegation for which the evidence would cause a reasonable person to conclude that the alleged act of misconduct is likely to have occurred.

[8]An allegation is unfounded in OPR's definition when the evidence would cause a reasonable person to conclude that the subject employee did not commit the alleged misconduct, or that, in fact, no misconduct occurred.

unsubstantiated.[9] Four of the seven substantiated cases involved employee misconduct, resulting in four terminations. According to OPR officials, three cases were still being adjudicated and the nature of the allegations was not provided. Additionally, 200 of the allegations were classified by OPR as either information only to facility management, requiring no further action, or were referred to facility management for action, requiring a response.

- CRCL also receives complaints referred from the OIG, nongovernmental organizations, and members of the public. Officials stated that from the period March 2003 to August 2006 they received 46 complaints related to the treatment of detainees, although the nature of the complaints was not identified. Of these 46 complaints, 14 were closed, 11 were referred to ICE OPR, 12 were retained for investigation, and 9 were pending decision about disposition.

- We could not determine the number of cases referred to DRO or their disposition. On the basis of a limited review of DRO's complaints database and discussions with ICE officials knowledgeable about the database, we concluded that DRO's complaint database was not sufficiently reliable for audit purposes. We recommended that ICE develop a formal tracking system to ensure that all detainee complaints referred to DRO are reviewed and the disposition, including any corrective action, is recorded for later examination.

- We reviewed 37 detention monitoring reports compiled by UNHCR from the period 1993 to 2006. These reports were based on UNHCR's site visits and its discussions with ICE officials, facility staff, and detainee interviews, especially with asylum seekers. Eighteen of the 37 UNHCR reports cited concerns related to medical care, such as detainee allegations that jail staff were unresponsive to requests for medical assistance and UNHCR's concern about the shortage of mental health staff.

- While American Bar Association officials informed us that they do not keep statistics regarding complaints, they compiled a list for us of common detainee complaints received through correspondence. This list indicated that of the 1,032 complaints it received from January 2003 to February 2007, 39 involved medical access issues such as a detainee

[9]An allegation is unsubstantiated in OPR's definition when the evidence is not sufficient for a reasonable person to determine whether the subject employee committed the alleged misconduct.

alleging denial of necessary medication and regular visits with a psychiatrist, allegations of delays in processing sick call requests, and allegations of a facility not providing prescribed medications.

Madam Chairman, this concludes my prepared remarks. I would be happy to answer any questions you or the members of the subcommittee have.

Contacts and Acknowledgments

For further information on this testimony, please contact Richard M. Stana at (202) 512-8777 or by e-mail at stanar@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement.

In addition to the contact named above, William Crocker III, Assistant Director; Minty Abraham; Frances Cook; Robert Lowthian; and Vickie Miller made key contributions to this statement.

Ms. LOFGREN. All of the witnesses, this is the time when Members of the Committee can pose questions. I will begin.

Ms. Myers, I would like to ask about the managed care structure in the Department. It is my understanding that there are three nurses here in Washington who are charged with reviewing all medical treatment requests that are submitted by the physicians who are actually examining patients who are detainees at the various sites.

I am not aware of any other system that permits nurses to overrule the judgment of the on-site physician who has actually examined a patient. Do you know of any other system that uses this?

Ms. MYERS. Thank you for that question. That will allow me to explain a little more about the TAR process and also about the independence that physicians have on site.

As a point of clarification, the TAR process is not used for routine medications or other decisionmaking that is made by physicians or other officials on site. The TAR process is used when there is something that is nonroutine or nonemergency. The TAR process is used after an emergency just for reimbursement. It is not an authorization for emergency care. So if there is a particular thing that appears to be, where you need an outside provider, the managed care coordinators are the ones that review that to see whether it falls within the benefits package.

I would say that ICE did not set up the managed care system. That is under the Public Health Service and DIHS, which has a managed care system not just for ICE, but also for the Bureau of Prisons and the United States Marshals Service which are also under that. They are the ones that placed that organization.

Ms. LOFGREN. If I may, there have been numerous complaints that have been brought to the Committee's attention not only by individuals, but through the press. For example, in *The Washington Post* series, which I assume you have read, there are several instances in which on-site medical personnel expressed their frustration by the refusal to authorize necessary medical care. And in the case of the York County prison, the county actual sued ICE for not authorizing care.

In the July 2007 GAO report, the GAO wrote, "Officials at some facilities told us that the special medical and mental health needs of detainees can be challenging. Some also cited difficulties in obtaining approvals for outside medical and mental health care as also presenting problems in caring for detainees."

Are you familiar with other facilities that have expressed concern about denial of care to detainees?

Ms. MYERS. The letter you referenced from the York County facility actually involved a 2005 letter, and it is our understanding Dr. Farabaugh and others just reached out to the York County facility yesterday, and maybe as soon as I finish my answer, I will have him go into more details with respect to that.

On the TAR process, generally it is less than 10 percent that are denied. I believe we need to look at the 10 percent that may be denied. Some may be properly denied. We have instances where we get a submission for an individual who is not in ICE custody. It would not be a good use of taxpayer money to pay for that, or something that is obviously elective.

Ms. LOFGREN. Was Mr. Casteneda's biopsy denied under the TARs system?

Ms. MYERS. That case is in litigation.

Ms. LOFGREN. But the Government has admitted liability.

Ms. MYERS. The Government has admitted liability, but I believe there is room for improvement in the TAR appeal process, and that is why we have asked the Office of Health Affairs, working in conjunction with the Division of Immigration Health Service, to look at how does the TAR appeal process work, and how do we make sure the alien has a role in that process.

Ms. LOFGREN. Let me ask you about forced sedation. In its four-part series, *The Washington Post* cited what they said was 250 medically unnecessary instances since 2003 in which ICE sedated a deportee against their will with what they called a "preflight cocktail," Haldol. It is my understanding on January 9 of this year, ICE headquarters issued a written guideline stating that the field offices may no longer request a medical escort from DIHS for involuntary sedation to facilitate deportation unless the Federal Government has obtained a Federal district court order authorizing sedation, and that there was to be no exception to this policy.

The ICE memorandum, I understand, further recommends that the court appoint counsel for aliens who are not represented or who are unable to obtain counsel.

Since this policy has been issued, how many Federal court orders have been issued authorizing sedation for deportation?

Ms. MYERS. If I can clarify just a little bit the information contained in your question, first of all, the policy directive that I requested be issued in June of last year said that we cannot do involuntary sedation absent a court order except in emergencies. And then in January of this past year, I said there is no emergencies, you know, court order, no matter what.

It is my understanding, on information and belief, that since June of last year, I believe there are four applications that did go to court, and I believe they are all still pending. But I would request the opportunity to put that in responses to the record to make sure that I accurately describe the answers to your question.

I will also add, I think this is just one of many areas in which ICE is examining decades-long practices and putting in enhanced oversight for things that have gone on for years, and where DIHS is very helpful.

Ms. LOFGREN. I am going to turn now to the Ranking Member Mr. King for his questions.

Mr. KING. Thank you, Madam Chairman.

It occurs to me as I listen to the testimony and some of the comments made, including my own, that if someone is incarcerated in an ICE facility, one can self-deport and simply say, send me home; I am not satisfied with the food or the bunk or the medical care. Ms. Myers, have you ever had that happen?

Ms. MYERS. There are occasions in which an individual is going through immigration proceedings, and they decide to terminate the proceedings, and so that does happen, yes.

Mr. KING. Does it ever happen with a complaint about the facilities, the food or the health care, or anything that has to do with

the environment that they are in other than the fact that they aren't free to travel?

Ms. MYERS. I have no specific knowledge, but I will get back to you in writing.

Mr. KING. I would very much like a response to that. It would be some interesting insight.

If it is so horrible, has anybody asked to leave because of the conditions they are in rather than just to avoid the legal process?

As I look at some memos that I have here, it shows that of the 27,500 ICE detention beds, 65 percent are located in State and local prisons or jail facilities; 19 percent commercial contract facilities; 14 percent are ICE-owned and operated; 2 percent Federal Bureau of Prisons. Has anyone broken down the data on the deaths during incarceration with regard to those separate categories?

The reason I ask the question would be, let's just say if it is a Federal prison or a State or a county, are they more likely to die in any of those facilities, or is it scattered across the board, or is there enough data for it to be significant? I ask you first, Ms. Myers.

Ms. MYERS. We would have to go back and make sure that we go through the statistics to give an accurate reporting.

But we expect individuals, no matter where they are housed, we expect individuals to live up to ICE standards. If they don't, we will do just like we did last year: We will move individuals out of those facilities, and in some instances even shut facilities down if we can't ensure that individuals in our custody are being treated in accordance with the ICE detention standards.

Mr. KING. I appreciate that.

Mr. Stana, could you discern any distinction between the data on let me say unhappy health results with regard to whether it would be a State or a local prison or a contract facility or an ICE-owned service?

Mr. STANA. We didn't make that distinction. Every location we went to, we asked if there had been a death in the facility. And of the 23 we went to, I believe 2 had a death in the facility. We didn't do a whole lot of probing, but in one case the person died in their sleep apparently of natural causes. And the other case, I believe, was a heart attack.

Ms. MYERS. If I can add one point to that, we are starting this reporting under the Death in Custody Reporting Act. I believe the Bureau of Justice Statistics will be able to do the same kind of metrics that they do with other facilities in terms of looking at statistical deviances and so on. So that will be one measure going forward that I think will be useful on that front.

Mr. KING. I will submit that if we are dealing with between 230,000 and 311,000 inmates a year, that there should be some statistical data that would point to a facility or a type of facility or something other than a random cross-section here. And one of these things I have here is our 2004 and 2005 mortality rate in our U.S. jails and prisons at 550 deaths in 2004 per 100,000; 540 deaths per 100,000 in 2005; and we are looking at ICE numbers of 10.8 or 6.8. Can you explain that, Ms. Myers?

Ms. MYERS. I am not a statistician, but we see that even the flat numbers of deaths that we are having, and any death is regret-

table, the numbers of deaths we are having is going down, even though the number of detainees are going up.

Some jails have very low lengths of stay, lower than in ICE custody, which is about 37½ days. Certainly there is a comparable thing there.

But many more detainees may not have health insurance than individuals who come into other facilities. All of these statistics are reasons why we have asked the Bureau of Justice Statistics to look at this as we start reporting.

We do have instances, unfortunately, like last year where someone was in our custody for about 72 minutes, and they had swallowed some cocaine while in State custody. It exploded within them, and they passed away.

Mr. KING. In your opinion would it be rational or irrational for this Congress to take action on a major policy change within ICE health care without answering these questions as to why there is a significantly lower death rate among ICE inmates than there are among inmates across the broad spectrum in other American prisons?

Ms. MYERS. I certainly think it makes sense to evaluate all of those things, and I think it also makes sense to consider whether or not in the proposed bill it is actually requesting a higher level of services than those provided to U.S. citizens or aliens who are detained in U.S. Marshals Service custody who have not yet primarily been convicted of a crime. I think it is important to look at those things, look at the costs, and get a sense of what kind of services are requested or expected.

Mr. KING. It is irrational to look at the data before making a decision.

Ms. LOFGREN. As I turn to Mr. Gutierrez, I want to correct for the record, under the Administration prior to the current Administration, there actually was a requirement that there be no sedation whatsoever on deportation, and that was changed.

I yield now to Mr. Gutierrez.

Ms. MYERS. May I just respectfully ask to respond to that?

Ms. LOFGREN. No, but you will have an opportunity to respond.

Ms. MYERS. I would like to respond to that statement prior to the end of the hearing.

Mr. GUTIERREZ. Thank you very much.

I think once again what we see here is we have a hearing, and then we blame the victim, those detained by ICE. We hear again the demonization of immigrants. They are all sick; 34 percent. Now we have an argument between Ms. Myers and the Ranking Member whether it is 34 or 25 percent.

They talk about chronic illnesses, hypertension. I am not afraid of anybody with hypertension or diabetes. They then repeat ad nauseam tuberculosis, something that is a contagious disease, to make it appear after this testimony they are all dangerously ill coming to this country.

I find it amazing that these very same people who are so dangerously ill are the same people who are taking away the jobs from Americans, showing up to work every day doing hard work, intense labor at meat-packing plants, picking up the food out in the fields under intense heat, and yet, well, a third of them have a chronic

illness. I wonder if that is the way it is for the rest of the American population.

It makes it feel like you offer, Ms. Myers, Rolls Royce health care. That is what we just hear from the Ranking Member, Rolls Royce health care. I almost feel after listening to the Minority that it is safer. I should maybe when I go to Chicago not check into my house, check into an ICE facility. It is probably safer there, according to the Minority, than it is on the streets of Chicago.

Mr. KING. Will the gentleman yield?

Mr. GUTIERREZ. I will not yield.

Mr. KING. It probably is.

Mr. GUTIERREZ. I said I will not yield.

It appears it is safer for me. Again, the demonization, the criminalization, we hear it all the time.

Let me ask Ms. Myers a question. How many people did you detain on the streets in work sites in America last year that you ultimately deported?

Ms. MYERS. I will have to get back to you in writing.

Last year we arrested administratively in work site 4,667 or so. In addition, we had 863 criminal arrests.

We take our responsibility extremely seriously.

Mr. GUTIERREZ. I know you want to control the hearing, but I have limited time, and I want to ask my questions.

How many people did you detain on the streets of America and deport last year?

Ms. MYERS. We deported almost 300,000.

Mr. GUTIERREZ. Three hundred thousand people, and you had more money to do that last year than you have had in previous years?

Ms. MYERS. Congress gave us more money to do that.

Mr. GUTIERREZ. And you have more money for next year so you can increase the level of deportations?

Ms. MYERS. Our responsibility is to enforce the immigration laws.

Mr. GUTIERREZ. Do you expect to have the capacity to deport more people next year than you did last year?

Ms. MYERS. Yes, I do expect that.

Mr. GUTIERREZ. What increase—do you think you will go from 300 to 330, so you have a 10 percent increase, a 20 percent increase? What do you think it is going to be?

Ms. MYERS. I will say that the number of aliens we charge in jail—we expect to charge over 200,000 aliens in jails this year.

Mr. GUTIERREZ. Okay, 200,000 this year. So next year you expect to deport at least 300,000 people next year?

Ms. MYERS. Well, not all of the aliens who are in jail, who are charged, who are going through immigration procedures, will get out of jail this year. But once they get out, assuming their orders are removed and not allowed to adjust in any way, yes——

Mr. GUTIERREZ. I know you want to emphasize on the criminalization of the population that you deal with. I am just asking you a general question, and I would really appreciate a specific answer to the question.

How many—according to ICE, how many undocumented workers or illegally present people are there in the United States of America?

Ms. MYERS. You know, I don't believe——

Mr. GUTIERREZ. You don't know.

Ms. MYERS [continuing]. There is a number on that.

Mr. GUTIERREZ. You don't know. You have no idea. You have no idea, and there is no documentation in ICE, under oath, that—you have no idea, and you have never in ICE or at Homeland Security come up with a number of undocumented workers in the United States.

That's your testimony?

Ms. MYERS. Well, certainly the Bureau of Immigration Statistics looks at——

Mr. GUTIERREZ. And they say there are how many?

Ms. MYERS. You know, that's not within my agency, so I am going to have to reflect——

Mr. GUTIERREZ. Fine. I will not comment on what has been statistically shown, since you don't know. You are the head person at ICE and don't have a number.

You know, I would think that if I had a population of people that I needed to police, I would at least have an estimate of how many people it was I had to police and deal with as part of my Federal responsibilities.

But it's your testimony here today that you cannot answer that question because you don't have a number.

Ms. MYERS. No, no, no.

Mr. GUTIERREZ. And because my time—let me finish. And because my time is up, it begs the question once again. What are we doing?

Ms. LOFGREN. The gentleman's time has expired.

Mr. GUTIERREZ. Because you know as well as I know that there have been estimates of between 12 and 20 million.

Ms. LOFGREN. The gentleman's time has expired.

Mr. GUTIERREZ. And at a rate of 300,000 a year, which you have been doing with lots of gusto, it would take us 25—with not one more coming in, which begs the——

Ms. LOFGREN. The time of the gentleman has expired.

Mr. LUNGREN. Privilege of the Chair, Madam Chairman.

Ms. MYERS. May I please respond to that question?

Ms. LOFGREN. The gentleman's time has expired.

I am going to take the privilege of the Chair to give you a minute to comment on the Bush administration's policy of requiring a court order in every case to sedate, to deport, which I promise to give you an opportunity to comment on, as well as a very brief response, before turning to Mr. Lungren.

Ms. MYERS. I appreciate that very much.

First, I will say upon information and belief—and we certainly would look forward to getting back to this in writing to you, I am not aware that that was the policy in the previous Administration and the former INS.

That was not my experience, which was why I believed that it was important to issue the directive which I did last summer.

If I could also respond to Congressman Gutierrez, what I said related to the U.S. for an estimate of individuals working, as opposed to an estimate of individuals who are currently here. Certainly the Office of Immigration Assistance, as well as the Pew Research Center—it does have—I can give those statistics to you.

I am going to turn now to the Ranking Member, Mr. Smith. I will give you the White House memo that outlines the Clinton policy.

Ms. MYERS. Well, it does follow the question that I had.

Ms. LOFGREN. I turn now to the Ranking Member of the full Committee, the honorable gentleman from Texas.

Mr. SMITH. Thank you, Madam Chair. Before we get back to the subject matter at hand, Secretary Myers, I don't want the record to misrepresent your knowledge.

Of course, you have a range of millions of people you know who are in the country illegally. Just because you can't give a precise figure actually points to a lack of a failure or a failure to enforce immigration laws; that's why we don't know how many people are coming into the country illegally.

But if you were to be asked, you would probably agree that there are 12 to 20 million people who are here in the country illegally, would you not?

Ms. MYERS. I would.

What I was responding to—his question was the individuals who were working. I believe there were some independent studies to talk about what percent of illegal aliens are working. They are not ICE studies.

I can't vouch for the Pew Center's numbers, but certainly I am aware of that.

Mr. SMITH. There are no specific numbers. All we have is sort of orders of magnitude. But, again, that points to the failure or inability to enforce immigration laws.

Let me get back to the subject at hand. You made the point earlier in your opening estimate that the number of deaths in detention facilities had traumatically declined over the last couple of years. What were those figures again?

Ms. MYERS. In calendar year 2007, there were seven deaths in our facilities. We had a detainee population of 323,000 individuals.

In calendar year 2006, there were 16 deaths in our facility.

If you look back to calendar year 2004, there were 29 deaths.

Mr. SMITH. The trend is dramatically down.

Ms. MYERS. The trend is dramatically down and the record-keeping is up.

Mr. SMITH. Right.

Ms. MYERS. When I look back at the——

Mr. SMITH. Was that true or reported in any of the critical articles, the substantial reduction in deaths?

Ms. MYERS. You know, certainly we had challenges with respect to *The Washington Post,* the implications that were there. We disagree with a number of them. We have a long letter into the office——

Mr. SMITH. Would it have been a more balanced approach to show the progress you have been making and compared how few deaths there were compared to past years, would it not?

Ms. MYERS. I think it would. That's why we have a formal complaint in.

Mr. SMITH. What else does your complaint encompass? Were there other inaccuracies or omissions that should have been included?

Ms. MYERS. There are a number of those. If you read the article, it implies suicides are up. Obviously, as my testimony indicated, we haven't had a suicide in the last 15 months. We are working very hard to do what we can to ensure that we have quality medical care.

The series didn't focus on the fact that we actually took over in a more direct fashion the administration of DIHS in order to ensure greater oversight. *The Washington Post* series failed to compare the treatment that DIHS provides with the Marshal Service system. Instead, it claimed that DIHS provided inadequate service and so on.

We certainly have a 5-page letter which I would be happy to provide to the Committee, if you would like.

Mr. SMITH. I would like to have a copy of that. I would also like to make it part of the record. It seems to me at the very least you are owed a correction or retraction on the basis of that article.

Ms. LOFGREN. Without objection, we will put into the record the articles as well as the letter.

Mr. SMITH. Thank you, Madam Chairman.

Mr. Stana, let me go back to your work at the GAO. You said, I think, that you only found examples of noncompliance, and I would say that some of them might be accurately described as minor in 3 of the 23 facilities that you visited; is that correct?

Mr. STANA. That is correct.

Mr. SMITH. In only three did you find the noncompliance of standards.

You also said they were not pervasive. Is that accurate as well?

Mr. STANA. These were the medical care standards. There is a distinction between quality of care. I wanted to point that out. But this involves things like, was the proper equipment on site, did they have access to a doctor, did they have medical emergency procedures? Were inmates given the opportunity to go to a sick call? Were there suicide watch procedures? Those kinds of things.

Mr. SMITH. In those 3 out of 23 facilities, 13 percent of the facilities, would you describe the problems that you found as comprising a hidden world of faulty administrative practices, sloppy record-keeping and lost medical files; or is that a slight exaggeration as to what you found in those 23 facilities?

Mr. STANA. I can tell you what we found at the 23 facilities.

We found some differences between the large ones and the small ones as to how much equipment was on hand. We found that they were clean, they were well attended to.

We did find there were some employee grievances—not employee grievances. There were detainee grievances. If there is an Achilles' heel to this whole process, it's the handling of those grievances.

We are talking about what the scale of this problem is. One way to find out is to use the grievance and the monitoring and the compliance mechanisms as the canary in the coal mine, because it is not reliable.

Mr. SMITH. Right. Again, no systematic noncompliance in those facilities?

Mr. STANA. We didn't find it, not at the facilities we were at.

Mr. SMITH. Great. Thank you very much.

I will yield back the balance of my time.

Ms. LOFGREN. The gentleman yields back.

I would now recognize my colleague from California, the gentlelady, Ms. Sánchez.

Ms. SÁNCHEZ. I thank the Chairwoman. Again, I just want to start—before I start questioning, I just want to point out something.

Much was made about the fact that detainees can voluntarily choose to leave if the food or the medical care treatment is that bad.

I might point out to my colleagues on the dais, if they didn't already know this, that there are many countries with whom we don't have repatriation agreements. It would be pretty hard for somebody to allow—voluntarily allow themselves to be deported to a country that we essentially can't send them back to, and that there are many asylum seekers that end up in detention facilities. They are not exactly anxious to go back to war-torn places where they may be targeted for death or other kinds of threats.

So I just wanted to make sure my colleagues on the dais understand it's not necessarily as easy as saying, well, pack me up and send me home because the medical care here is substandard.

In terms of questions, Ms. Myers, both *The Washington Post* and the Office of the Inspector General have cited the debilitating shortages of medical staff at detention centers. And at some facilities, vacancies in medical positions range anywhere from 20 to 50 percent.

Is that degree of lack of staff in compliance with the standards of the American Correctional Association or the National Commission on Correctional Health Care?

Ms. MYERS. Thank you for that question.

We certainly agree that there were some concerns with respect to staffing, and we had some issues at ICE with respect to moving along as quickly as we would like with ICE and getting the staffing up. That's why in October of 2007 we actually took DIHS over more formally for—and the administrative side to really work on the staffing.

Last January——

Ms. SÁNCHEZ. But my question was——

Ms. LOFGREN. I am going to interrupt. We have just been notified that an alarm has gone off, that a tornado is heading for the Capitol, and that we should stay away from windows and stay inside.

Since there are three windows right in back of us, I think that probably we should recess this hearing temporarily and move into that hallway.

Thank you. We are in recess.

[Recess.]

Ms. LOFGREN. That's the first time I have ever had to recess a hearing for a tornado. As a Californian, that's kind of a new thing for me.

We are trying to find Congresswoman Sánchez to let her know we are back in session, and also the other Members who recessed, to let them know that we are back.

So we will not use your time frivolously, I wonder, Mr. Davis, if you would like to begin your questioning while we notify other Members that we are back in session. Then we will let Ms. Sánchez resume her questioning when she returns.

So I would turn now to Mr. Davis.

Mr. DAVIS. Thank you, Madam Chairwoman.

Ms. Myers, I am from Alabama so I am not scared of tornados. You notice these California folks ran. The Iowan and the Alabaman stuck around.

Let me, Ms. Myers, try to get us refocused a little bit. I was reading your opening statement—didn't have a chance to hear you—but I was reading your opening statement or the transcript of it. And you talked for a moment about the quality assurance professionals who inspect the largest ICE facilities, and I want to ask you point-blank, how many of these quality assurance professionals are doctors?

And, as they conduct their quality assurance review, are they evaluating the facilities for their medical quality?

Ms. MYERS. Thank you for that question. I am from Kansas, and I am scared of tornados, being from Kansas.

But to be clear, the quality assurance professionals that are in our 40 largest facilities, those are focused on overall compliance with all our detention standards, so it's not solely on medical care. So these are individuals to make sure, if there is any issue with any particular detention center, they are there.

We do have a detention field inspection group, which is this independent arm operating under the Office of Professional Responsibility. They have a medical professional within that group, so they are able to go out and do target reviews.

But I think we can do more. That is the reason——

Mr. DAVIS. Well, you frankly said what I thought you would say. My sense, from reading your testimony and from reading the testimony of the other witnesses, is that it's a quality assurance review that is far more generalized and the medical review so that——

And, also, given your concession that we can do more, I make a proposal to you: Why not have the American Medical Association, a respected group of doctors, the equivalent of the ABA for lawyers, why not ask the AMA to appoint a panel of professionals to come in, review these facilities or to review at least perhaps 20 of them?

Ms. MYERS. Well, what—actually, what we have asked to do which is similar to that, but not precisely that, is to ask the Office of Health Affairs to look at—some experts that could do an overall review of all of DIHS processes. So they are finding experts, recognized medical experts, who can look and see, as DHS has taken over greater administrative control of the DIHS, what works, what doesn't work, where have things changed, where can we really do best practices?

So this is our review that is starting now.

Mr. DAVIS. Well, slow down for 1 second.

Ms. MYERS. Oh, sure.

Mr. DAVIS. That's a perfectly reasonable suggestion, but what about my AMA suggestion? Good idea or bad idea?

Ms. MYERS. Well, I think—I thought that some sort of—some sort of review, once we took DIHS over, was appropriate. That's why we conducted a baseline review of our own——

Mr. DAVIS. AMA, good idea or bad idea?

Ms. MYERS. What?

Mr. DAVIS. AMA, good idea or bad idea?

Ms. MYERS. Yeah. I think that—the OHA review that is going on, I think really encompasses—and so I think that is sufficient to do the kinds of things that both you and I want to do.

Mr. DAVIS. Not to be contentious, but I do want to try to get an answer because I mean it as a good-faith suggestion.

The AMA is an enormously respected entity that I assume is the equivalent of the ABA. I certainly don't think they are known as a partisan or democratic leaning entity in any sense of the word.

What's wrong with having the AMA come in and do a review?

Listen to what I think the advantage would be: having somebody other than the Federal Government take a look at the Federal Government, having somebody outside the governmental process come in. Because I think—and I think this is the concern that others have driven home to you, I think, Ms. Myers—that we can go back and forth on what's the quality of care and all of that.

I am going to ask you some questions about that in a moment, but if you are serious, and I take you at your word that you are serious about improving the quality of care at these facilities, it would seem that the best way to do that, is, frankly, not to have an intragovernmental review or even to have another Government agency conduct a review, but to frankly have an assessment by medical professionals.

I am going to move on as my time is about up, but I would seriously encourage you to give some thought to the idea of an outside medical entity such as the AMA coming in and doing analysis.

A final set of questions: Are you a lawyer, Ms. Myers?

Ms. MYERS. Yes, I am. Not a practicing lawyer.

Mr. DAVIS. What do you believe is the standard of care for the individuals who are held in these facilities?

Ms. MYERS. I believe that DIHS has a responsibility to provide medically necessary health care while at the same time ensuring proper obligation of Federal funds, to ensure that we don't overpay for anything.

Mr. DAVIS. Well, I would be curious in hearing—and perhaps in writing would be a better place for discussion on this, given the time limits, but I am seriously concerned about what DIHS considers to be the standard of care toward these individuals.

Is it analogous, for example, to the standard of care for people who are in Federal prison?

Ms. MYERS. Well, I think you raise an excellent point. I believe it is analogous to the standard of care for U.S. Marshal Service prisoners, individuals who are coming into Marshal Service custody who have not yet been convicted of a crime.

There may have been areas where it differs, but overall, it appears that that standard of care is very consistent. But, as I said, I am not a doctor.

Mr. DAVIS. Is that current policy? Is what you just said current policy?

Ms. MYERS. That is my understanding. But let me say that's why we asked the Office of Health Affairs to actually consult with outside professionals—not just to do an intragovernmental review—but to consult with outside Government officials and look at all the DIHS system processes and see where there's room for improvement.

I can see myself where there's room, but the doctors may have additional advice of counsel.

Mr. DAVIS. I see my time has expired.

Ms. LOFGREN. The time of the gentleman has expired.

We will turn now to the gentleman from Virginia, Mr. Goodlatte.

Mr. GOODLATTE. Thank you, Madam Chairman.

Ms. Myers, I would like to ask about one of the provisions in H.R. 5950 that has been introduced by the Chairman to address some of the concerns. That bill appears to require the Department of Homeland Security to provide continuity of care for a reasonable period of time after removal.

Do you read that to mean that the Department would be responsible for providing care to a detainee even after they are removed from the United States?

Ms. MYERS. Well, certainly. And I would caveat this with, obviously our lawyers are going to take a thorough assessment of the bill. The Administration will then take a position. But I do believe the language is vague in that it is just, you know, kind of what exactly is the continuity of care.

By the way, we do already provide continuity of care in certain instances. But I think we need to look at the language and understand what is expected.

Ms. LOFGREN. Would the gentleman yield?

Mr. GOODLATTE. I would be happy to yield.

Ms. LOFGREN. I don't have a copy of the bill in front of me, but the intent, and if we get to a markup, it for example, the medical records should be provided to the person if they are removed, and things of that sort; that there should be planning, not just dumping somebody.

Mr. GOODLATTE. But you wouldn't be contemplating providing actual health care after they are no longer under the jurisdiction?

Ms. LOFGREN. No. In fact, we have strongly suggested that for those individuals who are in custody with serious health care problems, that they be provided alternatives to detention standards, so they could bill their own insurance, instead of the Federal Government.

For example, if you have a chronic condition, and you are applying for a political asylum, why not put on an ankle bracelet and get your own care instead of being in detention?

But I thank the gentleman for yielding so I could clarify that.

Mr. GOODLATTE. I thank the Chairwoman for that guidance. I hope the language in the bill will be clarified to make it clear we are not providing care to people after they have been deported from the United States.

Ms. Myers, in your opinion, what is the maximum amount of time that would comply with the, quote, "reasonable period of time"

requirement that's described in the bill during which the Department of Homeland Security must ensure continuity of care for detainees after release or removal?

Ms. MYERS. You know, I couldn't really provide a precise number at this time, but I think both points are very valid that we would need to look at kind of what is expected.

Right now, in many instances we assist with follow-up appointments. We provide detainees, for example, with several days' worth of medication so that they could then go and find an additional doctor back in their own country or back in the United States.

With respect to asylum seekers, very few asylum seekers are detained. Of course, we do have our parole policy which provides that after they go through the considerable peer process they are considered for parole.

Mr. GOODLATTE. I also have concern about the phrase, "serious medical or mental health conditions," which are not defined anywhere in the bill, that would raise some questions about how you would draw the line between serious medical or mental health conditions and nonserious conditions.

Ms. MYERS. I think that's exactly right. The bill also talks about more comprehensive dental care and vision care than is provided to prisoners in the United States Marshal Service custody.

So I think there are a number of things that I think we should consider. What does the Congress want to find? We, as ICE, will implement, of course, whatever the Congress decides.

Mr. GOODLATTE. Let me ask you if the Department has considered the use of telemedicine to improve the quality of care that detainees receive while saving the taxpayer dollars. We have seen this utilized all across the country in prisons, in jails, and other places where having doctors immediately available, especially specialists, would be a considerable expense.

Ms. MYERS. I am going to have the doctor, if that's okay, respond to that.

Dr. FARABAUGH. We are actually actively pursuing a telemedicine system for our agency. This would mainly be utilized within DIHS facilities. Obviously we can't put equipment in every—you know, all 350 IGSA facilities out there that are used, but we can concentrate them with our own facilities to enhance the care that's provided.

Mr. GOODLATTE. Well, good. We hope you will do that, because I have seen it used very effectively in rural areas.

Let me also say that I am stunned by the progress that you have made in reducing fatalities, deaths in your facilities, but even more so by the comparison of mortality rates in U.S. jails and prisons and in your facilities. I see 10.8 per 100,000 a year in facilities and 550 in prisons. And in 2005, 6.8 compared to 540.

Is there some explanation for why your mortality rate is dramatically lower than it is in prisons?

Ms. MYERS. You know, I think certainly we are very pleased that we have been able to reduce the number of deaths, although absolutely any death is regrettable, I think. I am very proud of the care that DIHS provides the professionals that are there and the work that we do in order to make sure people get the best medical care.

Of course, individuals in jails may be in for a much shorter period of time than individuals in ICE custody. Individuals in prison may be in there for a much longer period of time than individuals in ICE custody.

So even—there are some variances, as well as the number of individuals with insurance; it may be much lower for individuals who come into our custody than for individuals who come into other custodies.

There are a number of factors, but I am very proud of the work that they do.

Ms. LOFGREN. The gentleman's time has expired.

Mr. Smith had asked to make a unanimous consent request to make a correction to his opening statement. I will recognize Mr. King for that purpose.

Mr. KING. Thank you, Madam Chairman.

I appreciate being recognized on behalf of Mr. Smith, who wishes to correct a statistic he cited in his opening statement.

The correct figure is that immigrants are over six times more likely to have tuberculosis than native-born Americans, not four times.

He appreciates your indulgence. I yield back.

Ms. LOFGREN. Without objection.

I understand that Ms. Sánchez would like to yield her remaining 3 minutes to Mr. Davis to continue his questions.

We are going to have votes pretty soon, so we will have to say goodbye to this panel.

Mr. DAVIS. Thank you, Madam Chairwoman. I will try to not take the 3 minutes.

Let me pick up, conveniently enough, on the last question Mr. Goodlatte asked about the decreasing mortality rate, which you contend is a very low mortality rate. You made this point, but frankly, you made it at a rapid pace. I want to slow down and make sure that everyone gets this.

I think it is enormously difficult to compare the ICE population with the prison population. One reason I suspect that people stay in American prisons a lot longer than people stay in ICE facilities: What's the average length of stay for someone at one of your detention facilities?

Ms. MYERS. The average length of stay in ICE facilities is actually between 33 and 37 days. Jails, in some American jails, the average length of stay is also in the 30 days—in that time period. But absolutely, in prisons it can be much longer.

Mr. DAVIS. So that's one reason. Obviously, very few people get sentences of 30 days in the American prison system, so that's one comparison.

You mentioned another having to deal with the level of the uninsured. I would suspect there are also some age differences. What's the average age of people in the ICE facilities?

Ms. MYERS. You know, I am going to have to get back to you on that in writing, so I can be positive.

I have seen, in jails, the average age—I think—in the Bureau of Prisons, I believe, the average age is 38, so, you know, kind of midlife.

But let me say, I agree with you that having a more robust analysis of the statistics would be useful. That's why we have asked the Bureau of Justice Statistics to take our statistics and look at them with all the other statistics under the Deaths in Custody Reporting Act. They can do the analysis, they have the statisticians. They can draw the comparisons that maybe we can't as effectively draw.

Ms. LOFGREN. Would the gentleman yield for a question?

Mr. DAVIS. Yes.

Ms. LOFGREN. One of the differences between people in your ordinary, for example, State prison and ICE detentions, number one, the ICE detention people aren't criminals. But, number two, the ICE detention people are oftentimes moved around whereas the prison population tends to be sedentary.

How do you—we have had a lot of complaints that medical files and medication don't get moved with detainees. How do you make sure that happens so that the medical care isn't deficient or, at the next facility, the person has to start over from scratch?

Ms. MYERS. Well, there are a couple of things that we do more generally, and a couple of initiatives, to make sure that we are comprehensively addressing this problem.

I think more generally if we have specific instances that are brought to our attention, we address them, we look at them. Obviously, the detainee standard addresses this as well as some of the standards that apply to DIHS.

But we are looking at our performance-based standards that are out for review by the Inspector General where we receive comments from the NGOs and other groups to make sure that the transfer standards make it clear about the transfer of the record——

Ms. LOFGREN. But there is a standard right now. Do you require that the files be sent with the inmate?

Ms. MYERS. A file—or in cases where we don't have access to a complete file, a summary of that information. Absolutely.

Ms. LOFGREN. And that their medication be transferred with them?

Ms. MYERS. That their medication be——

Ms. LOFGREN. That's what you require?

Ms. MYERS. That's what we require.

I believe there is some room for improvement on some of these, certainly in the IT area, the—you know, the DIHS IT system has a lot of room for improvement.

Ms. LOFGREN. Okay. Our time has expired, and we are out of Members who want to ask questions. So we will thank this witness for your presentation today.

The record will be open for 5 legislative days. There may be additional questions that we will forward to you in writing, and we would ask that those questions be promptly answered, if that happens.

We will now ask the next panel to come forward. I would like to introduce all of them.

First, I am pleased to welcome Dr. Homer Venters, Attending Physician at the Bellevue/NYU Program For Survivors of Torture, as well as a Public Health Fellow at New York University.

As part of Doctors of the World, Dr. Venters sees detained asylum seekers who are victims of torture, and his research involves health care for detained immigrants. Dr. Venters first became involved with immigration health care as a health volunteer while in the Peace Corps in Togo. His most recent publications deal with public acceptance of torture in the United States and health care for detained immigrants.

Next, I would like to introduce Ann Schofield Baker, a principal in the New York office of the law firm of McKool Smith, where she is the head of the firm's national trademark litigation practice. Along with her diverse practice, Ms. Schofield Baker maintains an active pro bono practice, through which she represented Amina Mudey, an asylee from Somalia who was detained at the Elizabeth Detention Center in New Jersey.

She is admitted to the New York, Washington D.C., and Massachusetts bars, and to the Federal District Courts in the Southern and Eastern Districts of New York.

Our next witness is Mary Meg McCarthy, Executive Director of the National Immigrant Justice Center, which she has led since 1998. NIJC serves approximately 8,000 asylum seekers, trafficking victims, unaccompanied immigrant children, detained adults, and other low-income immigrants each year, drawing on a network of 1,000 pro bono attorneys. Prior to joining NIJC, Ms. McCarthy practiced civil litigation at the law firm of Horvath & Lieber and served as a pro bono attorney for NIJC's asylum project.

Our next witness is Zena Asfaw, a former immigration detainee. Zena was born in Addis Ababa, Ethiopia, where she worked for Ethiopian Airlines. Having endured persecution at the hands of the Ethiopian Government, she fled Ethiopia and made her way to the United States, where she applied for asylum.

Upon arriving in the U.S., Zena was detained and held for 5 months in an ICE detention center. She was finally released when an immigration judge granted her application for asylum. She currently lives in Los Angeles and is employed by the Sheraton Delfina in Santa Monica.

Next, I would like to introduce Gloria Armendariz. Gloria is a U.S. citizen and is here to testify concerning her common-law husband, Isaias Vasquez, a veteran of the Armed Forces, who was detained for about 18 months in several detention facilities. After his release, Isaias was granted U.S. citizenship based on his military service.

Our next witness is the Reverend Roy Riley, Bishop of the New Jersey Synod of the Evangelical Lutheran Church in America, the largest Lutheran denomination in the United States. Bishop Riley serves on the board of directors of Lutheran Immigration and Refugee Services, which serves and advocates on behalf of refugees, asylum seekers, unaccompanied children, immigrants in detention, families fractured by migration, and other vulnerable populations.

Next is Mr. Edward Harrison, President of the National Commission on Correctional Health Care, a not-for-profit organization that provides standards and independent accreditation of correctional health services. Mr. Harrison advocates for a better understanding of the importance of appropriate medical and mental health care in

corrections facilities, and the relationship between correctional health care and the public's health.

He has been employed by NCCHC since 1986 and has been its president since 1993. He earned his Master's degree from Northwestern University's J.L. Kellogg Graduate School of Management and his undergraduate degree from the University of Illinois.

Our final witness is Mr. Isaac Reyes, partner with the government relations firm of Austin, Copelin & Reyes, which represents the U.S./Mexico Border Counties Coalition. Mr. Reyes spent 7 years working on Capitol Hill, most recently as policy adviser at the Senate Democratic Policy Committee, a leadership office of the former Democratic Leader of the Senate, Tom Daschle. Mr. Reyes received a Bachelor of Arts, with a major in political science, from California Polytechnic University at San Luis Obispo.

Each of your written statements will be made part of the record in its entirety. We are going to ask you to give about 5 minutes of oral testimony. But we are going to ask you to do this when we come back from voting.

All of those bells and whistles mean that on the floor of the House right now there is a vote going on. We have about 10 minutes left to get over there, and then I think there are four additional 5-minute votes. So what that means is at about 4:30, if we are lucky, we will be back here to hear your testimony.

So, relax, I think there's a coffee shop down the stairs if you want. We will be back, we hope, about 4:30. We are in recess until that time.

[Recess.]

Ms. LOFGREN. We have finished our voting for the next 2 or 3 hours. I would like to wait for the Ranking Member to arrive before we begin the testimony.

However, perhaps we could go through the formality of swearing each of you in. If so, would you stand and raise your right hands. I will read the oath, and you can say, yes, if you agree at the end.

[Witnesses sworn.]

Ms. LOFGREN. We notice that all of the witnesses have indicated in the affirmative.

Because several witnesses have transportation issues, I am going to ask that we get started, since the Ranking Member is on his way in. If we can start at the end with Mr. Reyes and then move right along, Mr. Harrison and the like.

So we are going to start with Mr. Reyes.

TESTIMONY OF ISAAC REYES, WASHINGTON REPRESENTATIVE, U.S./MEXICO BORDER COUNTIES COALITION

Mr. REYES. Thank you, Chairwoman Lofgren, Ranking Member King and Members of the Subcommittee, for inviting me for to testify about the U.S./Mexico Border Counties Coalition findings on the costs of providing medical care to undocumented immigrants.

The Border Counties Coalition is a nonpartisan policy and technical forum comprised of the elected officials from the 24 governments located on the Southwest border. Our efforts at the Federal level are focused on increasing the reimbursement levels for the costs associated with undocumented immigration resulting from the failure of the Federal Government to secure our borders.

Because of their proximity to the border, our member counties bear a disproportionate share of these costs. My testimony this afternoon is about the cost to border counties for providing health care to undocumented immigrants.

It is awkward to be discussing fiscal costs related to undocumented immigration when many of the witnesses this afternoon are addressing the loss of life and the horrific treatment of people in custody.

The focus of this hearing, the treatment of immigrants in detention, most of whom were, up to the time of their jailing, working and contributing members of their communities, whose only crime was to be living and working in the U.S. without permission, is an issue that needs more congressional oversight, and I urge continued examination of this problem.

Let me say clearly that our organization does not oppose the delivery of health care to undocumented immigrants. What we are saying is that the Federal Government should be responsible for these costs, not counties.

The Federal Government controls our Nation's borders and has the sole responsibility for developing and enforcing the immigration policy. The Federal Government's success or failure in protecting the Nation's borders directly affects State and local governments, particularly Southwest border counties.

Border counties receive pennies on the dollar when it comes to reimbursements from the Federal Government, whether we are talking about the State Criminal Alien Assistance Program, the Southwest Border Prosecution Initiative or Section 1011 Funds for Emergency Health Care reimbursement.

These three pots of money, developed as reimbursement programs, did not come close to making border counties whole. From 1999 to 2006, the 24 counties along the border spent a cumulative $1.23 billion to process criminals, undocumented immigrants, through the law enforcement and criminal justice systems. During that same time border counties only received $54 million in reimbursements from the Federal Government. Again, the costs were $1.23 billion, and only $54 million in reimbursements from the Federal Government.

In fiscal year 2006 alone the cost was 192 million. Of that 192, border counties received only $1.47 million. These are staggering costs, considering the rural nature and poverty level of most of these border counties.

Our 2002 study, entitled "Medical Emergency: Who Pays the Price for Uncompensated Emergency Medical Care Along the Southwest Border?" provides an estimate of the costs for providing emergency hospital and transportation services to undocumented immigrants. Our study determined that undocumented immigrants cost border hospitals $189.6 million in uncompensated emergency medical costs during 2000. To put this figure in context, total reported uncompensated costs at border hospitals were 831 million, meaning that costs attributable to undocumented immigrants comprised almost 25 percent of the uncompensated emergency room care.

In addition, we estimate that emergency medical service providers had 13 million in uncompensated costs, bringing the total to

more than 200 million in uncompensated emergency medical costs during 2000. Our study found that the former INS brought injured and ill-undocumented entrants to hospital and emergency rooms or called ambulances without arresting them, so that the Federal Government would not bear the cost of treatment.

Although the Federal Government reimbursed the States and counties for part of the costs they incurred for providing federally mandated and mercy health care services to undocumented immigrants, Southwest border counties are absorbing a significant and disproportionate amount of the costs.

The position of the Border counties Coalition is that the Federal Government should support the medical treatment of undocumented immigrants and pay for 100 percent of these costs. The Federal Government is responsible for the costs associated with undocumented immigration, not counties.

The costs to process undocumented immigrants come at the expense of basic, vital services to county residents. The unmet needs include libraries, jails, courtrooms, parks and basic infrastructure to colonias' new developments, flood prevention, social service programs for abused children and women, child care and after-school programs, but the overwhelming needs expressed by our elected officials are related to health care.

They need more ambulances, clinics, more indigent health care funding and more funding for comprehensive health care programs. These are basic services that lift the quality of life and communities. And the residents of border counties should not be asked to go without them because of the failure of the Federal Government to fully reimburse them.

Thank you for the opportunity to present the findings of our report, and I will be happy to answer any questions.

Ms. LOFGREN. Thank you very much.

[The prepared statement of Mr. Reyes follows:]

PREPARED STATEMENT OF ISAAC A. REYES

Chairwoman Lofgren, Ranking Member King, members of the subcommittee, thank you for inviting me to testify about the U.S./Mexico Border Counties Coalition findings on the costs of providing medical care to undocumented immigrants. I am the Washington representative of the Border Counties Coalition, a nonpartisan, policy and technical forum compromised of the elected officials from the twenty-four county governments located on the U.S./Mexico border. Our efforts at the federal level are focused on increasing the reimbursement levels for the costs associated with undocumented immigration resulting from the failure of the federal government to secure our borders. Because of their proximity to the border, our member counties bear a disproportionate share of these costs.

My testimony this afternoon is about the costs to border counties for providing health care to undocumented immigrants. It is awkward to be discussing fiscal costs related to undocumented immigration when most of the witnesses this afternoon are addressing the loss of life and horrific treatment of people in custody. The focus of this hearing—the treatment of immigrants in detention—most of whom were, up to the time of their jailing, working and contributing members of their communities whose only "crime" was to be living and working in the U.S. without permission—is an issue that needs more Congressional oversight and I urge continued examination of this problem.

The federal government controls our nation's borders, and has sole responsibility for developing and enforcing immigration policy. The federal government's success or failure at protecting the nation's borders directly affects state and local governments, particularly southwest border counties. Border counties receive pennies on the dollar when it comes to reimbursements from the federal government, whether we are talking about the State Criminal Alien Assistance Program, the Southwest

Border Prosecution Initiative, or Section 1011 funds for Emergency Health Care Reimbursement. These three pots of money, developed as reimbursement programs, do not come close to making border counties whole.

From 1999 through 2006, the 24 counties along the border spent a cumulative $1.23 billion on services to process criminal undocumented immigrants through the law enforcement and criminal justice system. During that same time, border counties received only $54.8 million in reimbursements from the federal government. In fiscal year 2006 alone, the cost was $192 million. Of that $192 million, border counties received one percent of the SCAAP appropriation—only $4.7 million came back to them. These are staggering costs considering the rural nature and poverty level of most of these border counties.

Many members of this subcommittee are well aware of the problems associated with SCAAP and are trying to improve that program. The recent passage of H.R. 1512, sponsored by Representative Sanchez and approved by this subcommittee, will bring more SCAAP funds to our counties and we thank you for your efforts and recognition of the problem.

Our 2002 study, entitled "Medical Emergency: Who Pays the Price for Uncompensated Emergency Medical Care Along the Southwest Border?" provides an estimate for the cost of providing emergency hospital and transportation services to undocumented immigrants. Our study determined undocumented immigrants cost border hospitals $189.6 million in uncompensated emergency medical costs during 2000. To put this figure in context, total reported uncompensated costs at border hospitals were $831 million, meaning that costs attributable to undocumented immigrants comprised almost 25 percent of the uncompensated emergency room care. In addition, we estimate that emergency medical service providers had $13 million in uncompensated costs, bringing the total to more than $200 million in uncompensated emergency medical costs during 2000. The $200 million broke down in the following manner: $79 million in California, $74 million in Texas, $31 million in Arizona, and $6 million in New Mexico. Our study also found that the former Immigration and Naturalization Service brought injured and ill undocumented entrants to hospital emergency rooms or called ambulances without arresting them so that the federal government would not bear the cost of treatment.

Yet, this $200 million figure does not represent the total costs borne by southwest border counties and local medical providers. Costs incurred for preventive, acute, extended or rehabilitative healthcare, and non-emergency medical transportation are not included in our estimate since these services fall outside the federal definition of an "emergency" and were therefore beyond the scope of our analysis. Furthermore, services delivered by a physician in a hospital's emergency department that are not paid by or through the hospital are billed separately and cannot be captured by examining uncompensated hospital costs. As such, costs incurred by physicians attending an undocumented immigrant in a medical emergency also are not included in our cost estimate.

The problem of uncompensated emergency services has far reaching implications beyond loss of hospital revenues. Health care costs and insurance premiums are rising, due in part to burgeoning levels of uncompensated care. Rising health insurance premiums are threatening business' ability, particularly small business, to offer employees affordable health care benefits. High liability costs and low levels of compensation are threatening the viability of emergency rooms and emergency transportation providers along the border. Some counties with high rates of uncompensated care can no longer afford to provide "charity" care for local needy residents. In some instances, high levels of unpaid medical bills related to undocumented immigrants have forced local healthcare providers to reduce staffing, increase rates, and cut back services.

The border counties health and health care systems face a much different set of issues than the rest of the nation. In 2007, the Border Counties Coalition released a report entitled, "At The Cross Roads: U.S./Mexico Border Counties in Transition." This report provided an in-depth analysis of the 24 border counties and compared them to the 50 states in our country. In terms of health care, the report found that if the border counties were considered a 51st state, it would rank last in the presence of health care professionals. Border counties would rank as the 50th state out of 51 in insurance coverage for adults and children. The prevalence of tuberculosis per 100,000 persons among residents of all border counties (10.4) is twice that of the United States (5.1) as a whole. Border county populations suffer higher rates of diseases, such as asthma, adult diabetes, and hepatitis, which are compounded by the low socioeconomic status characteristic of the population and a large migrating population between the United States and Mexico that relies heavily on public and charity health programs. As a significant segment of the population moves back and forth across the border, they become transfer agents of contagions and potential

illnesses. It is clear that border counties could use the money spent on health care for undocumented immigrants for health care needs for their own residents.

There has been a lot of heated debate about whether or not undocumented immigrants should receive free emergency medical care. Let me point out that Congress mandated this policy. In 1996, Congress passed two major laws that affect the delivery and financing of emergency services to undocumented immigrants. The first is the Emergency Medical Treatment and Active Labor Act (EMTALA), which requires hospitals and emergency personnel to screen, treat and stabilize anyone who seeks emergency medical care regardless of income or immigration status. The second law, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), among other things, limits Medicaid benefits for undocumented immigrants to emergency health services and non-Medicaid funded public health assistance (e.g., immunizations, communicable disease treatment). In addition, PRWORA requires states that want to provide non-emergency medical assistance to "non-qualified" immigrants to pass affirmative legislation before providing such services, even if the state already had such a law in place prior to the federal Act's passage.

Although the federal government reimburses states and counties for part of the costs they incur providing federally-mandated emergency health services to undocumented immigrants, southwest border counties are absorbing a significant and disproportionate amount of costs. The position of the Border Counties Coalition is that the federal government should support the medical treatment of undocumented immigrants and pay for 100 percent of the costs. The federal government is responsible for the costs associated with undocumented immigration, not counties. Few state resources are made available to help counties with this burden, so costs fall heavily on local taxpayers in these 24 counties along the border.

The costs to process undocumented immigrants come at the expense of basic, vital services to county residents. The unmet needs include libraries, jails, courtrooms, parks, and basic infrastructure to colonias, new developments, flood prevention, social service programs for abused children and women, childcare, and after school programs. But the overwhelming needs expressed by our elected officials are related to health care—ambulances, clinics, more indigent healthcare funding, and more funding for comprehensive healthcare programs. These are basic services that lift the quality of life in communities and the residents of border counties should not be asked to go without because of the failure of the federal government to fully reimburse them.

Thank you for the opportunity to present the findings of our report and for giving you a glimpse into the situation facing border counties. I will be happy to answer any questions.

Ms. LOFGREN. Mr. Harrison.

TESTIMONY OF EDWARD HARRISON, PRESIDENT, NATIONAL COMMISSION ON CORRECTIONAL HEALTH CARE

Mr. HARRISON. Thank you. I am pleased to be with you today to describe our organization's standards setting and accreditation processes.

The National Commission on Correctional Health Care is a not-for-profit organization that grew out of a project begun at the American Medical Association in the early 1970's. Our board of directors is made up of representatives of 38 major supporting organizations, including the AMA, the American College of Physicians, the American Nurses Association, the National Association of counties, the American Dental Association, the American Bar Association, the American Public Health Association and the National Sheriffs' Association. There was some comment earlier about getting the AMA or the ABA involved, and they are involved through our organization.

We are solely and completely dedicated to improving health services in our Nation's jails, prisons and juvenile confinement facilities. Our pioneering work began even before the Supreme Court's position in *Estelle v. Gamble* that inmates have a constitutional right to health care. So we have watched this field evolve and im-

prove over time and have helped the correctional systems and correctional health care professionals adapt to new challenges that were unheard of 30 years ago.

Our standards are based on three basic principles: that inmates should have access to necessary medical and mental health care, that assessment and treatment should be done by competent health care professionals, and that health care ordered by clinicians should be delivered without undue delay or interference. These principles may seem obvious and simple, but adhering to the standards is often complicated by the institutional nature of corrections.

Our standards are available to anyone. They have been used by State medical societies who have been contracted to review local correctional health care services. They have been used by the Department of Justice in its investigation into civil rights violations in correctional facilities, and by numerous consultants and other third parties hired by correctional systems to help evaluate and improve the quality of their care.

Even correctional systems accredited by other organizations, when confronted with growing problems, have asked us to conduct a review of their own facility and to make recommendations for improvement based on the NCAC standards.

Our organization advocates continuous quality improvements, CQI, as a great way for correctional systems to improve their operations. CQI, which is one of our standards, dictates that service staff actively seek out areas in need of improvement. The model embraces the discovery of problems as an opportunity to improve. From the thousands of correctional system reviews we have done over the past 30 years, I can say that what distinguishes the best systems from the mediocre is this culture of quality.

We never come across a perfect system. Indeed, the whole notion of CQI is that there is always room for improvement.

In the case of ICE facilities, ICE has taken the step of not only seeking accreditation from our organization, but from The Joint Commission on Accreditation of Health Care Organizations and others, and it is unusual in our field to see an organization take that step to seek multiple accreditations.

Several years ago I had the chance to go into an ICE facility, and I saw tremendous cooperation between the custody staff and the health staff. And that interplay between custody and health is a key component in a good correctional health care system.

Patient safety in this country, not just in corrections, is a huge problem. The Institute for Health Care Improvement estimates that each year as many as 15 million patient injuries occur in health care settings and between 100,000 to 200,000 deaths fromunintended injury. This is more deaths than would occur if a 747 jumbo jet crashed each and every day. So within the profession of health care we are well aware that unintended problems arise when treating patients. Within the world of corrections, as I mentioned earlier, treatment can be more complicated and, therefore, more susceptible to problems in the community.

I have read a number of press reports about the medical problems in some ICE detention facilities. It is always deeply troubling to hear about neglect and suboptimal care. Reports of these kinds require careful investigation and the warranted changes to improve

the system. Some of the reported problems had to do with custody staff action or inaction, which is not my organization's area of expertise. If there were critical performances involved, we were very, very concerned.

While we recognize that not every problem can be anticipated, we strongly believe that a correctional facility should be proactive in implementing patient safety systems to prevent near-miss and adverse critical events.

There should be an error reporting system for health staff to report, to voluntarily report in a nonpunitive environment, errors that affect patient safety; and all deaths should be reviewed promptly, both administratively and critically. In the cases of suicide, a psychological autopsy should also be conducted. Importantly, treating staff should be informed of any review findings and necessary corrective actions needed to be implemented.

Ms. LOFGREN. Mr. Harrison, could you sum up at this point? Your 5 minutes are up and we have many witnesses.

Mr. HARRISON. Thank you very much. I appreciate the opportunity to be here. I understand that some of the steps that ICE has taken, and I think that making improvements in systems is always possible. We will be glad to help the Committee and ICE.

Ms. LOFGREN. We do very much appreciate that offer of help.

Mr. HARRISON. Thank you.

[The prepared statement of Mr. Harrison follows:]

PREPARED STATEMENT OF EDWARD HARRISON

House Sub-Committee on
Immigration, Citizenship, Refugees, Border Security, and International Law

Hearing on: Problems with Immigration Detainee Medical Care

June 4, 2008

Testimony of
Edward Harrison, President
National Commission on Correctional Health Care

Members of the committee, my name is Edward Harrison and I am the President of the National Commission on Correctional Health Care (NCCHC). We accredit health services in some of the detention centers that house detainees of Immigration and Customs Enforcement. I am pleased to be with you today to describe our organization's standards-setting and accreditation processes.

The National Commission is a non-for-profit organization that grew out of a project begun at the American Medical Association (AMA) in the early 1970s. Our board of directors is made up of representatives of thirty-eight major supporting organizations, including the AMA, the American College of Physicians, the American Nurses Association, the National Association of Counties, the American Dental Association, the American Bar Association, the American Public Health Association, and the National Sheriffs' Association (see attached list). We are solely and completely dedicated to improving health services in our nation's jails, prisons, and juvenile confinement facilities. Our pioneering work began even before the Supreme Court's ruling in *Estelle v. Gamble* that an inmate has a constitutional right to health care. So we have watched this field evolve and improve over time, and have helped correctional systems and health care professionals adapt to new challenges that were unheard of 30 years ago.

Our standards are based on three basic principles: that inmates should have access to necessary medical and mental health care, that assessment and treatment should be done by competent health care professionals, and that health care ordered by clinicians should be delivered without undue delay or interference. These principles may seem obvious and simple, but adhering to the standards is often complicated by the institutional nature of corrections.

The NCCHC standards, or some adapted form of them, are used by detention and correctional systems throughout the country, but not by everyone. Adherence to the standards in most cases is voluntary (exceptions being, for example, when federal or state courts have required compliance, or when the standards have been stipulated in a contract between the government agency and a third party that provides the health

care services on site). Thus, in most cases, including with ICE facilities, we enter the premises as the guests of the legal authority.

Our standards are available to anyone. They have been used by state medical societies that have been contracted to review local correctional health care services, by the Department of Justice in its investigations into civil rights violations in correctional facilities, and by numerous consultants hired by correctional systems to help evaluate and improve the quality of their care. Even correctional systems accredited by other organizations, when confronted with growing problems, have asked us to conduct our own review of their facilities and to make recommendations for improvement based on the NCCHC standards. So I can state to the committee that our standards are widely recognized as the best standards for facilities that house ICE detainees to follow.

When we are asked to accredit a facility's adherence to the standards, we bring on site a skilled team of correctional health care clinicians and experts, who use a set of tools we have developed to ascertain and measure compliance. For an average size jail we might have three people on site for 2 or 3 days. The team always includes at least one physician.

We look to see if an appropriate system for the proper delivery of health care is in place. Prior to our visit we require the facility to post a notice of our upcoming review that encourages patients, staff, or visitors to contact us directly with any concerns they may have. We look at active medical records going back to the initial time of confinement to ensure that the quality of care we see when we are on site is typical of what the facility staff have been providing over time. We interview health staff, custody staff, and administrators as well as detainees and patients. We thoroughly review the facility's policies and procedures to see if there are any flaws in their system or if any component is missing. Then we look at the staff's performance in carrying out those policies, and verify that staff are credentialed and trained appropriately. When deficiencies are found, they are reported to the administrator and health authority, who must submit evidence of corrective action.

Our organization advocates continuous quality improvement (CQI) as a great way for correctional systems to improve their operations. CQI, one of our standards, dictates that facility staff actively seek out areas in need of improvement. The model embraces the discovery of problems as an opportunity to improve. From the thousands of correctional system reviews we have done over the past 30 years, I can say that what distinguishes the best systems from the mediocre is this culture of quality.

Patient safety in this country — not just in corrections — is a huge problem. The Institute for Healthcare Improvement estimates that each year as many as 15 million patient injuries occur in health care settings, and between 100,000 to 200,000 deaths from unintended injury. This is more deaths than would occur if a 747 jumbo jet crashed each day. So within the profession of health care, we are well aware that unintended problems arise when treating patients. And within the world of corrections,

as I mentioned earlier, treatment can be more complicated, and therefore more susceptible to problems, than in the community.

The National Commission on Correctional Health Care is a totally independent, unbiased organization obligated only to its mission to improve correctional health care. We have no "membership," do not collect dues. Furthermore, our volunteer leadership have been board members, on average, for over 9 years, and staff members, on average, have also been with us for that long.

I have read a number of press reports about medical problems in some ICE detention facilities. It is always deeply troubling to hear about neglect and suboptimal patient care. Reports of these kind require careful investigation and, when warranted, changes to improve the system. Some of the reported problems had to do with custody staff action or inaction, which is not my organization's area of expertise. But where clinical performance may be involved we are very concerned.

While we recognize that not every problem can be anticipated, we strongly believe that a correctional facility should be proactive in implementing patient safety systems to prevent adverse and "near-miss" clinical events. There should be an error reporting system for health staff to voluntarily report, in a nonpunitive environment, errors that affect patient safety.

All deaths should be promptly reviewed, both administratively and clinically. In the case of a suicide, a psychological autopsy should also be conducted. Importantly, treating staff should be informed of any review findings, and necessary corrective actions need to be implemented and monitored.

Our usual process is to conduct an on-site review once every three years. These reviews could be done more frequently, and it is my understanding that ICE does this through a third party using a modified form of our standards. We would encourage ICE to review its contracts and the contractors' performance to ensure it is getting the quality review necessary to meet its needs.

For security reasons our visits are planned well in advance and the facility staff are aware we are coming, although at some sites (none of them ICE), with the cooperation of the legal authority, we have also conducted unannounced, surprise accreditation visits. I would suggest that unannounced on-site reviews be considered at ICE facilities, as well.

I encourage members of the committee to refamiliarize themselves with our 2002 report to Congress, done at Congress' request, on the Health Status of Soon-To-Be-Released Inmates, available on the websites of the National Criminal Justice Reference Center, the National Institute of Corrections, or our own website at www.ncchc.org. Members may want to read our position statement on inmate abuse, also available on our website. And to see a sample of the type of thorough evaluation that is possible, I

would suggest committee members look for a copy of our report posted on the website of the Michigan Department of Corrections.

Thank you.

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NCCHC Supporting Organizations

Academy of Correctional Health Professionals
American Academy of Child and Adolescent Psychiatry
American Academy of Pediatrics
American Academy of Physician Assistants
American Academy of Psychiatry and the Law
American Association of Public Health Physicians
American Bar Association
American College of Emergency Physicians
American College of Healthcare Executives
American College of Neuropsychiatrists
American College of Physicians
American College of Preventive Medicine
American Correctional Health Services Association
American Counseling Association
American Dental Association
American Diabetes Association
American Dietetic Association
American Health Information Management Association
American Jail Association
American Medical Association
American Nurses Association
American Osteopathic Association
American Pharmacists Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society of Addiction Medicine
International Association for Correctional and Forensic Psychology
John Howard Association
National Association of Counties
National Association of County and City Health Officials
National Association of Social Workers
National District Attorneys Association
National Juvenile Detention Association
National Medical Association
National Sheriffs' Association
Society for Adolescent Medicine
Society of Correctional Physicians

Ms. LOFGREN. I now turn to Bishop Riley.

TESTIMONY OF THE REVEREND E. ROY RILEY, BISHOP OF THE NEW JERSEY SYNOD, EVANGELICAL LUTHERAN CHURCH IN AMERICA

Reverend RILEY. I am E. Roy Riley, Bishop of the New Jersey Synod of the Evangelical Lutheran Church of America, the largest Lutheran denomination the United States, about 5 million members, many good members in Iowa.

I thank Chairman Lofgren and Ranking Member King for the invitation to be here today.

Deeply woven into the Christian faith is love and concern for all of our brothers and sisters in the human family. The Bible is clear: Welcome one another just as Christ welcomed you. The bishops of the ELCA hold a special concern for the treatment of individuals held in the U.S. immigration detention system.

In just the past month, seven of my fellow bishops have visited three detention facilities in the States of Virginia, Michigan and Washington. I personally visited the detention system facilities in Elizabeth, New Jersey, and in New York.

Since the detention facility opened in Elizabeth, New Jersey, Lutheran Church members have been providing ministry to immigration detainees through weekly visits and have been providing ministry and pastoral care through a glass partition and over a two-way telephone as best they could.

In the course of these visits, our visitors have become aware of the very serious lack of appropriate medical care for detainees. These reports are documented in my written testimony and supported in various media reports. In fact, this very week a woman who came to this country seeking asylum from Nigeria and who was released from the Elizabeth Detention Center with full asylum 9 months after detention reported to me her story of inadequate medical treatment.

The reports of inadequate medical care for detainees and confiscation of needed medicines and medical equipment at arrest have foreshadowed the worst news of all that since 2003 at least 80 persons have apparently died either in detention or as a result of the lack of appropriate medical care while they were in detention.

Members of the synod I serve are troubled that it has required evidence of people dying to move Congress to take action. Of even greater concern to us is that a Nation that has so prided itself on the compassion expressed by that statue in New York Harbor could, by its own Government, treat immigrants and asylum seekers, our fellow human beings, in such a punitive way.

Three years ago, in 2005, the New Jersey Synod Assembly passed a resolution decrying the treatment of immigrants. Tomorrow, on June 5, our synod will convene again in annual assembly and we will consider adopting a resolution expressing our grave concern about the growing number of ICE raids targeting immigrants and, especially, the devastating effect these raids have on families, children and communities.

I fully expect the synod assembly to adopt that resolution, which will continue to provide guidance for thousands of our members

and help them as they work with their own legislative representatives.

Most of what is driving this discussion today is rooted in our own fears, primarily the fear for our own security and our own economic stability. When we are so driven by fear, it becomes something that is no longer helpful and, in fact, causes us to act in ways that are not true to our best selves.

On May 12, in the little town of Postville, IA, Government agents stormed into a workplace and arrested hundreds of people, handcuffing them and herding them to the Cattle Congress yards in Waterloo. In the process, hundreds of children were left not knowing where their parents were. The children were traumatized, both the immigrant children and children whose families had lived in Iowa forever. At the end of the day, teachers and administrators and citizens looked at each other and said, What happened here? What country is this?

It's time for us to act with common sense and good judgment and compassion, not just for the sake of immigrant men, women and children, but for our sake as human beings and citizens of a country that is supposed to be a model for human rights.

In light of these serious, systemic problems, I urge the Subcommittee to consider the following.

One, improve medical treatment and immigration detention. H.R. 5950 is a good step;

Two, improve conditions of detention; and

Three, cap expansion of detention and provide alternatives to detention. There are alternatives.

What I have said today will make no difference at all for 50-year Boubacar Bah, 35-year-old Francisco Castaneda, 45-year-old Sandra Kenley or 50-year-old Abdolai Sall. They and others like them have died in ICE-sponsored detention or as a result of the lack of appropriate medical care while in detention. What I have said will make no difference for them.

I have spoken today for the men and women and children who are still living, but being held in prison-like conditions as asylum seekers or immigrants without clear documentation. On behalf of the church I serve, I am lifting them up as brothers and sisters who need our help, the help of this Government.

But I am lifting up before you also the citizens of this country, myself included. We all need help in finding a just and sensible solution to the issue of immigration.

I thank you for your kind attention.

Ms. LOFGREN. Thank you, Bishop.

[The prepared statement of Reverend Riley follows:]

PREPARED STATEMENT OF REVEREND E. ROY RILEY

Testimony of

The Reverend E. Roy Riley, Bishop
New Jersey Synod of the Evangelical Lutheran Church in America

Before

The House Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law of the Committee on the Judiciary

Hearing on "Problems with Immigration Detainee Medical Care"

June 4, 2008

I am Roy Riley, Bishop of the New Jersey Synod of the Evangelical Lutheran Church in America (ELCA), the largest Lutheran denomination in the United States whose members comprise about 5 million congregants nationwide. While I am testifying in my capacity as Bishop, I am also a member of the Board of Directors of Lutheran Immigration and Refugee Service (LIRS), a cooperative agency of the ELCA, the Lutheran Church-Missouri Synod, and the Latvian Evangelical Lutheran Church in America. LIRS serves and advocates on behalf of refugees, asylum seekers, unaccompanied children, immigrants in detention, families fractured by migration, and other vulnerable populations.

I thank Chairwoman Lofgren and Ranking Member King for the invitation to speak before you today about the immigration detention system and the medical care and treatment of immigration detainees.

Lutheran Concern for the Humane Treatment of People in Detention
Deeply woven into the Christian faith is love and concern for all of our brothers and sisters in the human family. Jesus affirmed that loving our neighbor is second only and very near to loving God with all of our heart, mind, soul and strength. The same Jesus made it clear that no one is outside of God's love, and no one is to be outside of our compassionate reach, especially those who are in need. The Bible is clear: "Welcome one another, just as Christ has welcomed you, to the glory of God" (Romans 15:7).

Every human being is a child of God, created in God's image and deserving to be treated with dignity and respect. But, even a nonreligious, natural law would hold that a human being has certain inalienable rights. These include rights to liberty and personal security and protection against arbitrary detention; freedom from slavery, servitude or forced or compulsory labor; and the right to procedural due process.

The bishops of the ELCA hold a special concern for the treatment of individuals held in the U.S. immigration detention system. In 2006, the ELCA formed a committee of bishops to address immigration issues, which has repeatedly expressed concern about the immigration detention system. On October 4, 2007, I joined fourteen ELCA bishops, including all ten bishops of the Immigration Ready Bench, and LIRS president Ralston H. Deffenbaugh Jr., in issuing a statement to this Subcommittee on "Detention and Removal: Immigration Detainee Medical Care." (Attached herein). In the past two months, seven bishops of the ELCA have conducted delegation visits with our synodical and pastoral staff to immigration detention facilities under contract with DHS/ICE in Hanover, Virginia; Tacoma, Washington; and Detroit, Michigan. I have personally visited the Elizabeth, NJ detention facility and the Queens Contract Detention facility in New York.

Also, in 2007, LIRS and the Women's Commission for Refugee Women and Children released "Locking Up Family Values: The Detention of Immigrant Families," which documented grave problems with the medical services for immigrant families in immigration detention. (http://www.lirs.org/LockingUpFamilyValues.pdf).

Faith Ministry in Immigration Detention Facilities

Since the detention facility opened in Elizabeth, New Jersey, Lutheran church members have been providing ministry to immigration detainees through visits on a weekly basis and providing what pastoral care can be provided through a glass partition and over a telephone. Other denominations are making similar efforts. I am aware that Church World Service, Jesuit Refugee Service, and the American Friends Service Committee and other faith denominations provide non-proselytizing pastoral care visits to immigration detainees at several detention facilities, including some under contract with DHS.

In coordination with other faith denominations, on a monthly basis Lutherans hold vigil outside of the Elizabeth facility. The vigils serve the purpose of assuring those who are in detention that they are not alone and that members of the community are concerned about them and praying for them. The vigils also serve as a reminder to those holding vigil that we have brothers and sisters in great need, and to those who are in authority that the community is watchful.

Reports from Church Visitors, Lutheran Leaders, and Families

In the course of upholding the spirits and calming the fears of persons who have been incarcerated – rightly or wrongly – in detention facilities, our visitors have become aware of the very serious lack of appropriate medical care for the detainees. Detainees are sometimes provided medicines and treatments that are inappropriate for their medical needs. Increasingly we hear reports from families that at the time a person is detained, needed medications are taken away and often not returned after the person is processed for detention. Many detainees complained of being given only two choices for their ailments: "the blue pill or the red pill." Detainees often wait several days before receiving medical services after having submitted written requests for such care. It is reported that guards frequently told detainees not to bother them with sick requests. These reports and concerns are consistent with the disturbing accounts reported in the *Washington Post*, *New York Times*, and *60 Minutes* reports published in May 2008.

To all of this, I would add yet another report that was shared with me this week. A woman from Nigeria arrived nine months ago seeking asylum in the United States. She is theologically trained and was working as an evangelist in Nigeria, when her life was threatened. After nine months in detention, this Nigerian woman was granted full asylum and is living with a pastor's family in New Brunswick, NJ. What follows is her report of what happened while this asylum seeker was incarcerated in the Elizabeth detention center (EDC):

The Nigerian woman (name withheld) experienced depression while at EDC. A medication was prescribed. When it was being given one day, the pills dropped on to the floor. The nurse insisted that she take the pills anyway. She refused to take the contaminated medication. The EDC staff threatened to send her to the county jail for refusing. She was made to sign a document stating that she refused her medication. For two days she was not given any medication at all. On the third day she was given a completely different medication which incapacitated her for 24 hours. She could not get out of bed. She could not raise her head. She once again declined the medication following this incident.

On another occasion, (she) experienced a panic attack: sweating, panting, cold feet, rapid heart rate. The CCA officer on duty was informed and the officer contacted the medical staff. Nothing happened for over five hours. Her fellow detainees assisted her as best they could, with cool water on her face. When the medical staff finally arrived, they told her to drink some cold water. They told her they believed she was pretending to be ill.

Poor Medical Care for Detained Families - "Locking Up Family Values Report"
The 2007 report, "Locking Up Family Values: The Detention of Immigrant Families," issued by LIRS and the Women's Commission found instances of the failure to provide timely care, the lack of appropriate training for medical staff, or incorrect diagnoses at the T. Don Hutto Residential Treatment Center in Taylor Texas, one of two immigration detention facilities for families used by DHS. For example, detainees at Hutto often waited several days before receiving medical services after having submitted written requests for such care. Several pregnant women were not provided prenatal care at all or in a timely manner. One pregnant woman, Carmen, did not receive her first prenatal exam until she was seven months pregnant. Another woman recounted that she was given an x-ray to screen for TB without a lead protective cover, even after she told the technician she was five months pregnant. The recent investigative report from the *Washington Post* cited that nurses in an Arizona detention facility were performing x-rays in violation of state licensing requirements. The DHS/ICE response to a letter from the Arizona State Board of Nursing was that the facilities do not need to comply with the state standards.[1]

> *Rebecca, a detainee in Hutto, reported that her child was suffering from repeated vomiting. When she asked for medical attention, the staff told her that they would need to see the vomit to believe that her son was sick. When the woman's son had a toothache, she submitted a request slip to see the dentist. Her son waited three weeks before seeing the dentist. At that appointment the dentist pulled the rotten*

[1] "In Custody, In Pain, Beset by Medical Problems as She Fights Deportation, A U.S. Resident Struggles to Get the Treatment She Needs," Amy Goldstein and Dana Priest, *The Washington Post*, May 12, 2008.

> *tooth without any anesthesia. "My son was in terrible pain," Rebecca said. On another occasion, Rebecca experienced uterine pain and went to see the nurse who said she was not permitted to prescribe medicine. Her condition was not deemed an emergency. As a result, Rebecca waited more than one week before seeing the doctor who was called in on another case at 3:00 a.m. in the morning.*[2]

The "Locking Up Family Values Report" also found instances where Hutto detention facility staff misdiagnosed medical conditions and improperly treated patients. Several parents reported that medical personnel provided improper treatment for skin rashes. When one mother complained that her daughter began developing skin rashes, the facility staff told her mother that the condition was caused by an allergy to an antibiotic that had been prescribed to her at another facility. The staff took the antibiotic away. But the rash only became worse. The staff gave her a lotion, but the rash continued to worsen. After the daughter and her mother were released from custody, a pediatrician told her that the rash was not related to any allergy and prescribed a different medication which resolved the rash.[3]

Escalation to the Most Tragic Outcomes

The reports of inadequate medical care for detainees and confiscation of needed medicines and medical equipment at arrest have foreshadowed the worst news of all: that, since 2003, at least 80 persons have apparently died either in detention or as a direct result of the lack of appropriate medical care while they were in detention. The documentation of these deaths and other serious medical problems is continuing.

Members of my Synod are troubled that it has required evidence of people dying to force Congress to take steps to investigate the problem. Of even greater concern to my congregants is that a nation that has so prided itself on the compassion expressed by that statue in the New York Harbor, could by its own government treat immigrants and asylum seekers, our fellow human beings, in such an inhumane way.

2008 Lutheran Resolution on Raids and Medical Treatment for Immigration Detainees

Tomorrow, on June 5, our Synod will convene its annual Assembly, and will consider adopting a Resolution expressing our deep concern regarding the growing number of ICE raids targeting immigrants, and especially the devastating effect these raids have on families, children and communities. Three years ago, in 2005, in response to concerns from our church members, the New Jersey Synod passed a similar Resolution. That resolution decried the treatment of immigrants that parishioners and pastors observed in New Jersey detention facilities. (The full resolution is attached.). This year's resolution will re-affirm the 2005 resolution and all previous actions related to the conditions under which immigrant people are held in detention centers. The 2008 resolution will include special concern for issues related to the medical care and treatment of detainees. Having previously received strong support from our congregations and church members, I fully expect the Synod Assembly to adopt the proposed Resolution, which

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[2] Lutheran Immigration and Refugee Service and the Women's Commission for Refugee Women and Children, *Locking Up Family Values: The Detention of Immigrant Families* (February 2007) p. 22.
[3] *Ibid.*, p. 22.

will continue to provide guidance for our thousands of members as they seek to care for their neighbors and as they endeavor to make their legislative representatives aware.

The point that I am making is that we, as a Church, have been raising these concerns for a number of years. More and more people in our State and in this Nation are coming to understand the plight of those who have immigrated to this country. Democracy means that government is not only *of the people* and *for the people*, it is also *by the people*. That means that we understand our personal and corporate responsibility for these immigrants who have come to our shores. We cannot continue to condone the kind of governing that places the lives of these fellow human beings in such jeopardy. It is time to take action. The proposed legislation on medical treatment for detainees is a small but necessary step in a needed movement toward comprehensive immigration reform.

Congress Must End Inhumane Detention Practices
While the recent news reports offer gut-wrenching documentation of the problems with medical treatment, the basic concerns raised in these reports are not new. Yet, in the face of mounting evidence, such as the GAO and OIG reports from previous years, Congress has paid scant attention to the conditions of immigration detention.

As a leader in the Lutheran community, I question our government's escalation of the use of detention for immigrants who pose no threat to public safety or flight risk, especially when many have come here seeking asylum and other relief. Such practices should not continue in the United States, a country founded upon principles that uphold the liberty and fundamental dignity of every human being. To subject immigrants to harsh detention without adequate health care services and medical treatment is nothing short of stripping them of their dignity and humanity.

Indeed, when the detention facilities reach capacity and the new detainees are farmed out to county jails, they are often literally stripped, searched for drugs at the whim of their jailers, along with the criminal population residing in the jail. It is, by their own reports, humiliating.

The answer is not to build more detention facilities. The United States already leads the world in the proportion of its population in prison. There are more humane and economical ways for the government to carry out its enforcement.

Living in Fear
Most of what is driving this discussion today is rooted in our own fears: primarily the fear for our own security and our own economic stability. When we are so driven by fear, it becomes something that is no longer helpful, and in fact causes us to act in ways that are not true to our best selves. We have seen this played out most recently in South Africa, where South Africans took clubs and other weapons and killed refugees from Zimbabwe who had fled their own country seeking safety and a way to feed their children. The South Africans were afraid and then suspicious and then angry and the tragic results are plain to see. When we act out of fear and continue to live that way, we are neither sensible nor just in dealing with strangers, with immigrants.

On May 12 in the little town of Postville, Iowa, government agents stormed into a workplace and arrested hundreds of people, handcuffing them and herding them to the Cattle Congress yards a few miles away for questioning. In the process, hundreds of children were left not knowing where there parents were. The children were traumatized – both the immigrant children and children whose families had lived in Iowa forever.

At the end of the day, teachers and administrators and citizens would look at each other and say, "What happened here? What country is this?"

We are acting out of our own fears: fear for our security and fear that somehow the immigrants are stealing our wealth, our jobs, our hard-earned rights. We have turned the wrath of our fears upon people who are not our enemies. We are becoming the ones others fear. It is time for us to act with common sense and good judgment and compassion, not just for the sake of immigrant men, women and children, but for our own sake as human beings and citizens of the country that is supposed to be the model for human rights.

Recommendations
In light of these serious systemic problems, I urge the Subcommittee to consider the following:

1. **Improve medical treatment in immigration detention.** Congress should adequately fund health care for all persons in immigration detention and mandate DHS to improve medical services in detention facilities. The ELCA New Jersey Synod and LIRS support H.R. 5950 and S. 3005, important first steps in reforming immigration detention.

2. **Improve conditions of detention.** Congress should ensure that detention conditions are humane and that individuals have meaningful access to quality legal, social, and pastoral services, in addition to medical care.

3. **Cap expansion of detention.** Congress should suspend any pending legislation that would increase the use of detention or detention capacity. Expansion of the immigration detention program would be imprudent when there are humane, fiscally responsible and proven alternatives to imprisonment.

4. **Provide alternatives to detention.** Congress should mandate the development and immediate implementation of nationwide use of alternative to detention programs that include community based social services. These have been shown to ensure high appearance rates at immigration court hearings because they provide released immigrants with services such as access to vital, emergency services such as housing and legal assistance. Secure alternative to detention programs cost about one tenth the price of detention, which is $100 per day per detainee. Congress should codify standards for alternatives to detention programs to ensure proper implementation and oversight of these programs.

In Conclusion
What I have said here will make no difference at all for 50 year-old Boubacar Bah, 35 year-old Francisco Castaneda, 23 year-old Victoria Arellano, 81 year-old Joseph Dantica, 45 year-old Sandra Kenley, 60 year-old Young Sook Kim, or 50 year-old Abdolai Sall. They and others like them have already died in ICE sponsored detention. Many, if not most of these, died because they simply didn't receive the medical care they should have received. What I have said today will make no difference at all for them.

I have spoken today for the men, women and children who are still living, but being held in prison-like conditions as asylum seekers or immigrants without clear documentation. In behalf of the church I serve, I am lifting them up as brothers and sisters who need our help, the help of this government.

But I am also lifting up before you all of the citizens of this country, myself included. We all need help in finding a just and sensible solution to the issue of immigration. I implore the members of this Congress to lead us toward a day when we deal with the new and long-time immigrants among us not out of fear, but out of a sense of compassion and with a commitment to preserving the dignity and safety of those who have come in peace, seeking to make their home with us.

I thank you for your kind attention.

The Rev. E. Roy Riley
Bishop, New Jersey Synod
Evangelical Lutheran Church in America

Ms. LOFGREN. We would now be honored to hear from you, Ms. Armendariz.

TESTIMONY OF GLORIA ARMENDARIZ,
WIFE OF ISAIAS VASQUEZ, FORMER DETAINEE

Ms. ARMENDARIZ. I'd like to thank the Committee for inviting me. It's an honor for me on behalf of Isaias Vasquez.

My name is Gloria Armendariz, and I am a United States citizen. I reside in San Antonio, TX, with Isaias Vasquez, who immigrated to the United States from Mexico when he was 2-years old, served in the United States Army during the Vietnam War, and recently became a naturalized U.S. citizen. I have lived with Isaias for over—for more or less 30 years.

After many years of suffering from mental illness, he was diagnosed in 1990 with schizophrenia, was hospitalized over 18 years at the Audie Murphy Memorial Veterans Hospital. He was also hospitalized and received treatment for schizophrenia at the North Texas State Hospital following an arrest for possession of marijuana.

Isaias' conviction for drug possession led to the detention and removal proceedings in November of 2004 by the Department of Homeland Security. Until August 2005, he was detained in San Antonio at the GEO facility.

I visited Isaias every week while he was detained in San Antonio, and a number of times I was concerned he was not receiving adequate medical attention. Isaias complained that he was having side effects from the medication he received and was fainting. He said that the detention staff did not believe him. He was mentally ill or fainted. On two occasions, I learned that he fell and hit his head. When I complained to the detention staff, I was told that Isaias was fine and did not need additional medical attention.

In August of 2005, Isaias won his immigration case. When the immigration judge granted his application under the Convention Against Torture, the judge found that Isaias would likely suffer torture in Mexico due to the mental illness.

DHS did not appeal from the judge's decision, but Isaias was not released and was, instead, transferred to the South Texas Detention Complex at Pearsall, TX. There his condition became much worse. I was unable to see Isaias as often because of the distance from San Antonio to Pearsall. It was a hardship for me. But Isaias complained that he was not receiving his medications and that he was not fed properly and that he was being punished and put in segregation.

When I saw him, he was frail and undernourished. He seemed unstable and disoriented. A few times I tried to see Isaias, but I was told that he did not want to see me.

In January 2006, I learned that the DHS believed Isaias did not have schizophrenia, and it was trying to get the immigration judge to rescind the order allowing Isaias to stay in the United States. Later I found out that in November 2005 the medical staff at the detention center diagnosed Isaias with unspecified personality disorder and that thereafter they decided to take Isaias off his medication for schizophrenia and depression. Isaias became very sick and was put on suicide watch.

He smeared feces and spit in his cell. He became very disoriented and refused his other medications for diabetes and high blood pressure. He was punished by the detention staff. They put him in solitary confinement and gassed him. This was like 6, 7 months in there.

I tried the best I could to get help for Isaias. Our immigration lawyer made requests to DHS to release Isaias. I called Advocacy, Inc., an organization which helps individuals with disabilities. I spoke to the detention center warden. I contacted my congressman's office a lot of times. I filed complaints with the FBI, six, seven times. Suddenly, in May 2006, DHS, our lawyer, was told that Isaias was being released.

I drove to Pearsall, TX, to get him. I was stunned at his condition. And, when I got there, Isaias was very thin. His feet were swollen. He was covered with sores and was ranting. I was afraid of him because he was so sick, disoriented, and they also told me that he had TB.

I asked the Dr. Johnson to transfer Isaias to the VA hospital to transport him, because I was afraid, and he refused and said Isaias was not sick. I don't have it here, but there was like a SWAT team all around me—the warden, a lady taking a videotape of us. And I was pleading to them, Don't, I am afraid to take him, but I still had to leave with him.

So I drove him straight to the VA in San Antonio, I learned when I got there that Dr. Johnson had already called the VA and told them that there was nothing wrong with Isaias. So at first the VA would not admit him though for many years he had been treated for schizophrenia at that hospital.

I refused to take him. When Isaias became violent, the VA staff had to subdue him. And several people on the staff, they had to subdue him and finally they admitted him to the psychiatric ward.

Isaias remained there for about 2 months and was put on the medications which had been discontinued at Pearsall.

On January 30, 2007, at a hearing with the immigration, DHS agreed to dismiss the removal case so Isaias could apply for naturalization. On September 27, 2007, Isaias was granted naturalization based on his military service.

Now he has good and bad days, but he still suffers from the treatment memories of Pearsall.

[The prepared statement of Ms. Armendariz follows:]

PREPARED STATEMENT OF GLORIA A. ARMENDARIZ

My name is Gloria Armendariz. I am a United States citizen and I reside in San Antonio, Texas with Isaias Vasquez, who immigrated to the United States from Mexico when he was 2 years old, served in the U.S. Army during the Vietnam War, and recently became a naturalized U.S. citizen. I have lived with Isaias for over 30 years. After many years of suffering from mental illness, he was diagnosed in 1990 with schizophrenia. Isaias was hospitalized over 18 times at the Audie L. Murphy Memorial Veteran's Hospital (VA) in San Antonio, Texas. He was also hospitalized and received treatment for schizophrenia at the North Texas State Hospital following an arrest for possession of marijuana.

Isaias's conviction for drug possession led to his detention and removal proceedings in November, 2004 by the Department of Homeland Security (DHS). Until August, 2005, he was detained in San Antonio at the GEO facility. I visited Isaias every week while he was detained in San Antonio, and a number of times I was concerned that he was not receiving adequate medical attention. Isaias complained that he was having side effects from the medication he received and was fainting.

He said that the detention staff did not believe he was mentally ill or had fainted. On two occasions I learned he fell and hit his head. When I complained to the detention staff I was told that Isaias was fine and did not need additional medical attention.

In August, 2005, Isaias won his immigration case when the Immigration Judge granted his application under the Convention Against Torture. The judge found that Isaias would likely suffer torture in Mexico due to his mental illness. DHS did not appeal the judge's decision, but, Isaias was not released and was instead transferred to the South Texas Detention Complex at Pearsall, Texas. There his condition became much worse. I was unable to see Isaias as often because of the distance from San Antonio to Pearsall, but Isaias complained that he was not receiving his medication, that he was not fed properly and that he was being punished and put in segregation. When I saw him he was frail and undernourished. He seemed unstable and disoriented. A few times I tried to see Isaias, but I was told that he did not want to see me.

In January, 2006 I learned that DHS believed Isaias did not have schizophrenia and it was trying to get the Immigration Judge to rescind the order allowing Isaias to stay in the United States. Later I found out that in November, 2005 the medical staff at the detention center diagnosed Isaias with "unspecified personality disorder", and that thereafter, they decided to take Isaias off his medication for schizophrenia and depression. Isaias became very sick and was put on suicide watch. He smeared feces and spit in his cell. He became very disorientated and refused his other medication for diabetes and high blood pressure. He was punished by the detention staff—they put him in solitary confinement and gassed him.

I tried the best I could to get help for Isaias. Our immigration lawyer made requests to DHS to release Isaias. I called Advocacy Inc., an organization which helps individuals with disabilities. I spoke to the detention center warden, contacted my congressman's office, and filed complaints with the FBI

Suddenly, in May, 2006 DHS our lawyer was told that Isaias was being released. I drove to Pearsall, Texas to get him and I was stunned at his condition when I got there. Isaias was very thin, his feet were swollen, he was covered with sores and he was ranting. I was afraid of him because he was so sick, and I asked the doctor, Dr. Johnson, to transfer Isaias to the VA hospital. He refused and said that Isaias was not sick. So, I drove him straight to the VA hospital in San Antonio. I learned when we got there that Dr. Johnson had called to the VA and told the staff that there was nothing wrong with Isaias. So, at first the VA would not admit him, even though for many years he had been treated for schizophrenia at that hospital. I refused to take him home, and when Isaias became violent, the VA staff had to subdue him and he was finally admitted to the psychiatric ward. Isaias remained at the VA hospital for several weeks and was put back on the medications which had been discontinued at Pearsall.

On January 30, 2007 at a hearing with the Immigration Judge, DHS agreed to dismiss the removal case so Isaias could apply for naturalization. On September 27, 2007 Isaias was granted naturalization based on his military service. Now, he has his good and bad days, but he still suffers from the memories of his treatment at Pearsall.

Ms. LOFGREN. Thank you very much for sharing your story.

Ms. Asfaw?

TESTIMONY OF ZENA T. ASFAW, FORMER DETAINEE

Ms. ASFAW. Good afternoon. My name is Zena Asfaw. I am a political refugee from Ethiopia.

I arrived in the United States November 15, 2006, fleeing persecution from my home country. Upon arrival, I asked for political asylum in the United States. I was taken into custody by immigration officials and remained in custody for about 5 months until the immigration judge granted my political asylum application on April 10, 2007.

Because of the trouble and difficulty I endured in my country, I will never regret making the decision to leave. I am alive, safe, and I am grateful to the United States for giving me refugee.

I was transferred to the immigration detention center in San Pedro, California, after complaining about being unable to sleep be-

cause I was nervous about being deported. I was seen by a psychologist. He prescribed medication that was supposed to relax me and allow me to sleep the night.

One day, I had a near-death experience due to the negligence of the attending nurse. On this day, between 7 and 8 p.m., the attending nurse gave me seven pills to take at the same time. In the evening, I was only supposed to take two pills.

Also, the pills she was giving me were different in color and shape than my regular pills. I asked her if she was sure those were my pills. She became angry and told me loudly to swallow them. Then she instructed the security guard to check my mouth to make sure that I did not hide the pills in my mouth. The guard used a flashlight to examine my mouth. I believe I was forced to take the medication that I am not sure were not mine.

Immediately my body started shaking. I feel so cold. I thought I was freezing to death, but at the same time I was sweating. I went to my bed to lay down. Within a minute, I had a seizure and my body began to shake so violently that I fell off the bed on the floor.

I was taken to the immigration center medical unit where the same nurse who had given me the wrong pills examined me. She took my blood pressure, gave me another four pills, and ordered the guard to take me back to my bed. I spent the entire night shaking and sweating.

In the morning, a different nurse came to give me my pills. She noticed that I was shaking and sweating, and she asked me what was wrong. I told her what happened the night before. The ICE officer immediately took me to the hospital. At the hospital, I had my stomach pumped. I was taken back to the detention center.

The next day, I was still feeling sick. I was vomiting continuously. I lost control of myself and fainted. I start bleeding from my mouth and my private parts. A fire department ambulance came and took me to the hospital. I was still vomiting.

At the hospital, numerous tests were done on me. The examining doctor came and informed me that the test results showed damage on my liver, and he said he needed to do more tests. He said ICE would be informed about the results.

It took about a month for me to feel better. I needed help from other detainees to dress, bathe and walk. During this month, I was only given medication to manage my pain. I couldn't even go to the bathroom by myself.

I had my attorney call ICE and request my medical record. He was refused and told that I personally had to request these documents. I have requested all of my medical record on numerous occasions. To date, I have not received any of my records to this day.

I am not sure to what extent my health has been damaged. I was never officially told that I was given the wrong medication. It was only in passing that one of the male nurses told me that he was sorry that I had been given the wrong medication.

I have repeatedly request that I be informed about my test result, especially regarding my liver. I have just recently obtained health insurance and have taken tests.

Ms. LOFGREN. It's all right. Take your time. Take a breath.

Ms. ASFAW. I hope that those tests will finally allow me to find out what, if any, permanent damage was done to my health while I was in detention by ICE.

I hope that my testimony helps this Committee to evaluate the state of medical care within the ICE detention centers. Thank you.

[The prepared statement of Ms. Asfaw follows:]

PREPARED STATEMENT OF ZENA T. ASFAW

Hello, my name is Zena Asfaw. I am a political refugee from Ethiopia. I arrived in the United States on November 15, 2006, fleeing persecution from my home country. Upon arrival, I asked for political asylum in the United States. I was taken into custody by Immigration officials, and remained in custody for about five (5) months until an Immigration Judge granted my political asylum application on April 10, 2007.

I had never considered coming to the United States until I was jailed, beaten, and sexually assaulted after being arrested by the Ethiopian government. In late June of 2005, after the May elections in my country, the government arrested me for what they believed was my participation in the opposition party. There were many demonstrations regarding the legitimacy of the elections. Many believed that the government had committed fraud to win the election and to retain power. The government began to crack down on opposition party members as well as anyone they believed might be involved with the opposition. I was arrested after a police officer grabbed my cell phone and found some messages that had been sent to me by someone who did not support the government.

I was held for 12 days and released after I was forced to sign a document stating that I would not involve myself in any political movements. After I was released, I went to the hospital because I was having physical/female problems because of the sexual assault. I was given some medication for my symptoms.

I tried to put what happened to me at the jail out of my mind. I tried to move on with my life, continuing to work. In late October of 2005, there was a riot that happened after a demonstration. People were demonstrating once again against the government because of the fraudulent elections. The government began to arrest and detain opposition party members and anyone they suspected of being such. Soon after this, I received a letter from the police asking me to report for questioning regarding the riots. I decided to flee my country in order to save my life. I fled first to Kenya on October 27, 2005 and arrived in Los Angeles on November 15, 2006. It took me 13 months, traveling through 17 countries to arrive here.

Because of the troubles and difficulties I endured in my country, I will never regret making the decision to leave. I am alive and safe and I am grateful to the United States for giving me refuge.

Upon arrival in the United States, I was photographed, fingerprinted, X-rayed and then transferred to the Immigration detention center located in San Pedro, CA. Upon arrival at the detention center I went to the medical unit and reported having female problems. I was given some antibiotics, which did not help.

After complaining about not being able to sleep because I was nervous about being deported, I was seen by a psychologist. The psychologist concluded that these problems were because of what I had experienced in Ethiopia, together with the stress of being under deportation proceedings. He prescribed medication that was supposed to relax me and allow me to sleep at night.

After taking this medication for about four or five days I found it difficult to wake up and get involved in the daily activities of simply dressing and feeding myself. I told the attending nurse of the problems I was having because of the medication and informed her that I would no longer take them. I requested to see the psychologist. Within a couple of days I saw the psychologist and told him how the medication was affecting me. He changed the prescription. The new medications were working for me. I remained on them for over a month.

One day I had a near death experience due to the negligence of the attending nurse. As is the procedure, it is the attending nurse that gives all the detainees their medication. On this day, between 7 and 8 pm, the attending nurse gave me seven pills to take at the same time. In the evening, I was only supposed to take two pills. Also the pills she was giving me were different in color and shape than my regular pills. I asked her if she was sure that those were my pills and told her that I was supposed to only take two at night. She became angry and told me loudly to swallow them. Then she instructed the security guard to check my mouth to make sure I did not hide the pills in my mouth. The guard used a flashlight to ex-

amine my mouth. I believe I was forced to take medications that I am sure were not mine.

Immediately my body started shaking. I felt so cold that I thought I was freezing to death, but at the same time I was sweating. I went to my bed and lay down. Within minutes I had a seizure and my body began to shake so violently that I fell off the bed onto the floor.

The other detainees became alarmed and thought that I was dying. They yelled and made all kinds of noise to get the attention of the security guards. The guards, sensing the severity of the situation, cleared the room. I was taken to the detention center medical unit where I was seen by the same nurse who had given me the wrong pills. She took my blood pressure, gave me another four pills and ordered the guards to take me back to my bed. I spent the entire night shaking and sweating.

In the morning a different nurse came to give me my pills. She noticed that I was shaking and sweating and asked me what was wrong. I told her what had happened the night before. She looked at my chart and immediately locked up all the medication she was going to dispense and called ICE officers. The officers immediately took me to the hospital. At the hospital, I had my stomach pumped so that I would throw up the medication that was inside me. The doctor asked me why I was taking so many medications. I told him that I was only taking medication for depression and for sleeping. I remember that he said there was some kind of allergy medication that had been given to me. I was then taken back to the detention center.

The next day I was still feeling sick. I was vomiting continuously. I lost control of myself and fainted. Again, the other detainees started making noise and yelling as they had done before. Emergency was called and two nurses came. I was taken to the medical unit at the facility by wheelchair and examined. They gave me an I.V. and I started bleeding from my mouth and my private parts. The nurses noticed the severity of my situation and ordered a lock up of the detention facility. A fire department ambulance came and took me to the hospital again. I was still vomiting.

At the hospital numerous tests were done on me. The examining doctor came and informed me that the test results showed damage to my liver and said he needed to do more tests and that ICE would be informed about the results.

It took about a month for me to feel better. I needed help from other detainees to dress, bathe and walk. During this month I was only given medication to manage my pain. I couldn't even go to the bathroom by myself. The other detainees needed to help me with just about everything. Sometimes the guards would also help me. Also during this time the detainees and myself were told to sign some document which absolved the facility from liability for dispensing medications related to depression and difficulty sleeping. I refused to sign.

I had my attorney call ICE and request my medical records. He was refused and told that I personally had to request these documents. I requested all my medical records on numerous occasions. To date, I have not received any of my records.

To this day, I am not sure to what extent my health has been damaged. I was never officially told that I was given the wrong medication. It was only in passing that one of the male nurses told me that he was sorry that I had been given the wrong medication. I have repeatedly requested that I be informed about my test results, especially regarding my liver. I have just recently obtained health insurance and have taken some tests. I hope that these tests will finally allow me to find out what if any permanent damage was done to my health while I was detained by ICE.

I hope that my testimony helps this committee to evaluate the state of medical care within the ICE detention centers around the country.

Ms. LOFGREN. Thank you so much. I know that your testimony was difficult to give.

Ms. McCarthy?

TESTIMONY OF MARY MEG McCARTHY, DIRECTOR, NATIONAL IMMIGRANT JUSTICE CENTER

Ms. MCCARTHY. Thank you, Madam Chairwoman and Members of the Subcommittee. I am grateful for this opportunity to testify in support of the Detainee Basic Medical Care Act of 2008. I have submitted my written testimony for the record, and I would like to offer the following prepared remarks and then take your questions.

I think the testimony of my colleagues here has been very moving and powerful and illustrates so many of the issues that we see at the National Immigrant Justice Center.

I am the director of the National Immigrant Justice Center, a program of Heartland Alliance For Human Needs and Human Rights, based in Chicago, Illinois. The National Immigrant Justice Center coordinates the largest network of pro bono attorneys in the country, providing legal representation to approximately 8,000 individuals each year, including low-income immigrants, refugees, victims of human trafficking, unaccompanied children and asylum seekers. Our diverse client base and firsthand observation of different detention facilities gives us a unique perspective on detainee health care.

Across the country, U.S. Immigration and Customs Enforcement contracts with more than 300 local county jails to detain noncitizens held in administrative custody. Many of these facilities are located in remote, rural areas, far from lawyers and other service providers.

In Illinois and Wisconsin, the National Immigrant Justice Center regularly visits county jails under contract with ICE to offer legal rights orientations, conduct individual intake, and accept individual cases for representation.

In the thousands of detention cases that the National Immigrant Justice Center has handled during the past 10 years, we have witnessed a constant stream of complaints about the denial of adequate medical care. These complaints range from treating common colds to managing serious, permanent illnesses, such as issues relating to reproductive health care, to diagnosing and treating the physical and mental trauma resulting from torture.

I think it is also very important that we look at the numbers of days that individuals are staying in detention. We have heard this afternoon that the average length of stay is approximately 37 days. However, as my colleagues have testified today, that is not always the case.

In those cases where individuals are detained for longer periods of time, it is critical that those individuals have access to adequate medical care. In fact, the General Accounting Office statistics indicate that approximately 5,660 detainees of the 283,000 who were deported in fiscal year 2006 that were detained for more than 210 days, or roughly 7 months.

And as my colleagues testified today, many of those individuals are not here illegally. They have legal claims. Many were granted relief. They were granted immigration status in the United States.

I briefly want to talk about one particular case from the Midwest. My written comments explore a wide range of areas regarding health care, but the one particular case I will describe involved an Algerian asylum seeker, Ms. Hassiba Belbachir who came to the United States seeking asylum. She was taken into custody in McHenry County Jail in Illinois.

She suffered from severe depression, she told a nurse of her desire to take her own life, and repeated this cry for help to a social worker shortly thereafter. Instead of scheduling an emergency appointment with a psychiatrist, the nurse put Ms. Belbachir on a list to see the psychiatrist at his routine weekly jail visit 4 days later. Ms. Belbachir committed suicide before that appointment. The jail-issued socks wrapped around her neck asphyxiated her.

Ms. Belbachir's story shows what is wrong with our detainee health-care system. She was an asylum seeker with a serious mental health problem. Because she had no effective advocate and because, like the other 30,000 noncitizens detained by ICE on a daily basis, her case was all but invisible to the public and any number of civic organizations or even State agencies that might have come to her aid. In addition, the county jail did not comply with ICE detention standards. Staff did not conduct a comprehensive initial medical screening upon Ms. Belbachir's arrival. Her subsequent care was inappropriate.

ICE authorities knew that this facility had a history of failing to provide adequate screening to immigrants and failed to adequately train staff. And while ICE has detention standards, it has steadfastly refused to codify them. Thus, the standards are legally unenforceable, leaving immigrant detainees and their advocates little recourse.

How do we prevent future deaths and ensure that immigrant detainees receive proper medical care? The Detainee Basic Medical Care Act is a necessary first step. Among its requirements, each immigrant in ICE custody must receive a comprehensive medical and mental health screening upon arrival at a facility and a comprehensive examination. Appropriate personnel must have access to medical records to ensure proper treatment.

Ms. LOFGREN. Could you summarize at this point?

Ms. MCCARTHY. Yes, I'll be happy to wrap up.

In conclusion, adequate health care is a critical component of humane detention conditions. When lives hang in the balance, maintaining humane detention conditions will depend upon oversight, transparency and accountability, from Washington, DC, to local ICE contract facilities. Lifting the veil of secrecy shrouding the immigration detention system and starting an honest discussion about its humanity and fairness would be a great start.

Thank you for this opportunity.

[The prepared statement of Ms. McCarthy follows:]

PREPARED STATEMENT OF MARY MEG MCCARTHY

I. INTRODUCTION

Thank you, Madame Chairwoman and members of the Subcommittee. My name is Mary Meg McCarthy. I have served as Executive Director of the National Immigrant Justice Center, a program of Heartland Alliance for Human Needs & Human Rights, for 10 years. Prior to joining the organization, I represented asylum seekers as a *pro bono* attorney. I am grateful for the opportunity to testify in support of the Detainee Basic Medical Care Act of 2008.

Madame Chairwoman and members of the Subcommittee, medical care for people who are detained in this country is in critical condition. It is but one symptom of a dysfunctional immigration system.

This afternoon, I would like to provide a brief overview of the broken health care system for immigrant detainees, detail examples of the battles fought by the National Immigrant Justice Center to obtain health care and urgent treatment for immigrants in detention, and make recommendations for reform. The Detainee Basic Medical Care Act will greatly improve the quality and delivery of care to detained asylum seekers and other men and women in administrative detention. In addition to this critical function, it will remove the veil of secrecy that shrouds the deeply flawed immigration detention system.

The National Immigrant Justice Center, or NIJC, is a legal aid organization based in Chicago. In addition to direct service, NIJC litigates in the federal courts and advocates for systemic reform with policy makers. NIJC and its *pro bono* partners provide legal representation to approximately 8,000 individuals annually, including

low-income immigrants, refugees, victims of human trafficking, unaccompanied minors, and asylum seekers. During the past 25 years, NIJC has developed the largest network of *pro bono* attorneys in the United States, totaling more than 1,000 attorneys from leading law firms.

Throughout most of the nation, the U.S. Immigration and Customs Enforcement, or ICE, contracts with local county jails to detain non-citizens held in administrative custody. Many of these facilities are located in remote rural areas, far from immigration lawyers and social service providers. Strict secrecy regarding the disclosure of information regarding administrative detainees keeps them further isolated.

NIJC regularly visits the Illinois and Wisconsin county jails under contract with ICE to offer legal rights orientations, conduct individual intake, and accept cases for representation of non-citizens held in ICE custody. Immigration detention is administrative, not criminal, in nature. Unlike individuals held in criminal detention, immigrants in administrative custody have no right to court-appointed counsel. Despite the best efforts of NIJC and other legal aid organizations, only about ten percent of detainees obtain sufficient legal counsel.[1] Thus, legal rights presentations are often the only opportunity for detained immigrants and asylum seekers to gain an understanding of their legal rights and the available avenues for complaint and redress.

The government has broad authority to decide who is detained and for what duration, with little oversight and virtually no checks-and-balances. As a result, the system is arbitrary and lacks transparency. NIJC's direct representation of detained clients and its regular presence in the jails gives it a unique, insider's perspective on ICE's persistent failure to provide basic health care, respond to urgent needs, conduct vigorous oversight, and take corrective action. Despite this insight, much of the data obtained by NIJC related to detention conditions is garnered through requests under the Freedom of Information Act and federal litigation.

The medical staff and guards at ICE contract facilities have proven to be more open to communication with advocates and service providers than the federal agencies. In 2003–04, NIJC conducted a program under which it educated jail staff on the medical and mental health needs of the immigrant detainee population, and trained them to better understand the unique and often tragic experiences of asylum seekers, torture survivors, and victims of domestic violence in immigration detention. This project, which was implemented in Illinois, Michigan, and Wisconsin, was well received by medical staff and guards at the jails, who welcomed information on areas of medicine in which they were unfamiliar, such as tropical medicine and infectious diseases. The project also addressed practical issues, such as conducting medical exams through interpreters. Throughout this project, NIJC staff tried to work with the Division of Immigration Health Services (DIHS) to share our findings and seek its involvement, but to no avail. DIHS all but ignored our attempts to collaborate and improve conditions for these men and women.

II. OVERVIEW OF THE BROKEN HEALTH CARE SYSTEM FOR ICE DETAINEES

The use of administrative detention for non-citizens has skyrocketed during the past 12 years. In 1996, the U.S. government had a daily immigration detention capacity of 8,279 beds. By 2006, that number had increased to 27,500, with funds appropriated for future expansion.[2] In fiscal year 2007, more than 322,000 non-citizens were held in immigration detention facilities,[3] with a daily average of approximately 33,000 detainees. According to ICE officials, approximately 350 facilities that hold immigrant detainees operate under Intergovernmental Service Agreements (IGSAs). An additional eight service processing centers (SPCs) are owned and operated by ICE, and seven contract detention facilities (CDFs) are operated by private contractors such as Corrections Corporation of America or the GEO Group.[4] Most of the

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[1] According to the *Washington Post*'s recent series on health care in immigration detention, only one in ten detained immigrants have legal representation. Dana Priest and Amy Goldstein, "As Tighter Immigration Policies Strain Federal Agencies, The Detainees in Their Care Often Pay a Heavy Cost," *Washington Post*, May 11, 2008. In fiscal year 2006, only 48% of *all* non-citizens were represented by counsel in immigration court proceedings. United States Department of Justice, Executive Office for Immigration Review, FY 2006 Statistical Year Book, G1 (2007).

[2] Jorge Bustamante, Report of the United Nations Special Rapporteur on the Human Rights of Migrants, Mission to the United States of America, A/HRC/7/12/Add.2, 5 March 2008, at 11.

[3] Testimony of Gary Mead, before the House Subcommittee on Immigration, Hearing on "Problems with ICE Interrogation, Detention, and Removal Procedures," February 13, 2008.

[4] For a list of CDFs and SPCs, *see* "Semiannual Report on Compliance with ICE National Detention Standards January-June 2007," U.S. Immigration and Customs Enforcement Office of Detention & Removal (released May 2008).

IGSA facilities are county jails that were not designed to hold a civil detainee population for what can be months or years.

The May 2008 reports by "60 Minutes," *The New York Times*, and *The Washington Post* revealed the shockingly sub-standard conditions under which many asylum seekers and other non-citizens are held in federal custody. Eighty-three immigrants have died in custody in the past five years.[5] Countless others have suffered immeasurably while they or their loved one begged ICE to provide care. The press has done an admirable job of educating the public and policy makers on the sorry state of this system. Sadly, these reports were not news to many advocates. In NIJC's extensive experience, immigration detainees frequently have to fight to obtain basic medical care and treatment for life-threatening conditions. Many never receive care, especially those with limited English language fluency and no legal representation.

ICE detention facilities are governed by the ICE Detention Standards, which were negotiated between the Immigration and Naturalization Service (INS) and the American Bar Association, to apply to facilities that hold non-citizens in ICE custody for 72 hours or more. ICE adopted these standards when it succeeded the INS, but it has steadfastly refused to codify the standards in statute or regulation, leaving the standards legally unenforceable. This is a fundamental point. Immigrant detainees and their advocates have little recourse when the government refuses to enforce its own rules.

While ICE touts its expenditure of funds on immigrant health care,[6] as described below, only a few DIHS nurses decide whether or not to authorize the thousands of requests for treatment that are submitted by on-site medical care staff in these jails.

III. DOMESTIC AND INTERNATIONAL HUMAN RIGHTS LAW REQUIRES ADEQUATE HEALTH CARE

The United States is a nation that values liberty and respects the rule of law. We do not deprive individuals of liberty without due process of law, regardless of their nationality or alienage. Our due process protections include the right to humane treatment while in custody. Of course, people in immigration detention are in administrative, not criminal custody. Many have no criminal record whatsoever, having arrived on our shores seeking asylum or protection from torture. Others have committed only minor civil infractions and have no serious or violent history. As a result, our immigration detention facilities are filled to a significant degree with immigrants who pose no threat to our communities and who should be released on parole, into secure alternative programs, or under orders of supervision.

A host of constitutional principles and international laws govern the treatment of individuals in custody. All individuals in this country—regardless of their legal status—are protected by the Eighth Amendment (made applicable to the states by the Fourteenth Amendment), which prohibits cruel and unusual punishment. International human rights law also requires that all individuals in custody be treated humanely, regardless of citizenship status. For example, Article 10 of the International Covenant on Civil and Political Rights (ICCPR) states that "all persons deprived of their liberty shall be treated with humanity and with respect for the inherent dignity of the human person."[7] Torture and cruel, inhuman, and degrading treatment are outlawed by the Universal Declaration of Human Rights (UDHR)[8] and the Convention Against Torture (CAT).[9] The ICCPR and CAT were both ratified by the United States; the UDHR is accepted as universal law. In addition, United Nations guidelines call for non-discrimination while in custody, prompt medical care and attention, access to hygiene and sanitary conditions, and health care that meets national and community standards.[10]

The United Nations High Commissioner's Guidelines on Applicable Criteria and Standards Relating to the Detention of Asylum Seekers call the detention of asylum

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[5] Dana Priest and Amy Goldstein, "System of Neglect," *Washington Post*, May 11, 2008.

[6] ICE has stated that it spent nearly $100 million in fiscal year 2007 on medical care for detainees. ICE Statement for the Washington Post, May 7, 2008, *available at* www.ice.gov/pi/detainee_health_wash_post_statement.htm.

[7] International Covenant on Civil and Political Rights art. 10, December 19, 1966, 99 U.N.T.S. 171.

[8] Universal Declaration of Human Rights art. 5, December 10, 1948, U.N.G.A. res. 217 A(III).

[9] Convention against Torture, and Other Cruel, Inhuman or Degrading Treatment or Punishment arts. 2 and 16, December 10, 1984, 1465 U.N.T.S. 85.

[10] *See*, e.g., United Nations Standard Minimum Rules for the Treatment of Prisoners, May 13, 1977, Economic and Social Council res. 2076 (LXII); Body of Principles for the Protection of All Persons under Any Form of Detention or Imprisonment G.A. res. 43/173, annex, 43 U.N. GAOR Supp. (No. 49) at 298, U.N. Doc. A/43/49 (1988).

seekers "inherently undesirable."[11] The Guidelines recognize that there may be circumstances in which detention of asylum seekers becomes necessary.[12] However, in those situations the Guidelines are unambiguous: "Conditions of detention for asylum seekers should be humane with respect shown for the inherent dignity of the person." The Guidelines state that "the permissible exceptions to the rule that detention should normally be avoided must be prescribed by law."[13]

Due process also affords detained non-citizens the right to counsel, which has proven to be a near prerequisite to obtaining basic health care in immigration detention. However, rights are meaningless if they cannot be effectuated by the individuals they are meant to protect. Because non-citizens in custody are not provided counsel (although they are entitled to it), the right to adequate health care is a battle that many are left to fight on their own from remote and isolated detention facilities, a battle not often won.

IV. DIHS POLICIES VIOLATE APPLICABLE LAWS AND ICE'S OWN DETENTION STANDARDS

The ICE Detention Standard on Medical Care, while far from perfect, requires that, "All detainees shall have access to medical services that promote detainee health and general well-being."[14] But because the standard is not enforceable, it remains, in effect, "aspirational." Unfortunately, the policy that seems to exercise greater influence over provision of medical care to ICE detainees is implemented by the Division of Immigration Health Services (DIHS) in Washington, D.C.

As a matter of policy, DIHS errs on the side of refusing treatment to people who need care. The results are dangerous for detainees and frustrating to many jailers. In fact, the Deputy Warden of York County Prison in York, Pennsylvania, where federal immigration officials have held detainees for years, famously wrote to the local ICE office that DIHS had "set up an elaborate system that is primarily interested in delaying and/or denying medical care to detainees."[15]

In fact, the DIHS mission statement is contradictory to provisions of the ICE Detention Standard on Medical Care, which provides for at least basic medical care for the duration of detention. DIHS provides health services only for emergency care, defined as a "condition that is threatening to life, limb, hearing or sight." In short, the DIHS mission, as revealed in a document obtained by *The Washington Post*, is to keep the detainee "medically ready" for deportation.[16] This view was reiterated by Mr. Gary Mead, Acting Director of ICE Detention and Removal Operations, who questioned whether care was necessary as long as the detainee was "medically capable" of being removed.[17]

Another significant barrier to obtaining health care is the fact that requests for treatment that are made by medical personnel on-site in the jails must be submitted to off-site DIHS Managed Care Coordinators (MCCs). These are three nurses, not doctors, who are based in Washington, D.C. These three MCC nurses currently receive and review the medical requests submitted by on-site staff in the jails, effectively serving all 33,000 individuals currently in ICE custody across the nation.[18] According to *The Washington Post*, in one recent month, the MCCs received 3,000 requests for care.[19] Working five days per week, at this rate, each of the three MCC nurses would have to review and respond to approximately 50 requests per day.

In a press conference on May 21, 2008, Chairwoman Lofgren described changes to DIHS policy that raise additional concerns about the quality of medical care provided under this system. Apparently, until 2007 an MCC nurse had the authority to approve requested medical care, but not to deny it. Cases that an MCC rec-

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[11] "UNHCR Revised Guidelines on Applicable Criteria and Standards Relating to the Detention of Asylum Seekers," United Nations High Commissioner for Refugees (February 1999), Geneva, *available at* http://www.unhcr.org.au/pdfs/detentionguidelines.pdf. Although UNHCR's guidelines are not binding, they represent how UNHCR, the agency charged with supervising the application of the Refugee Convention, believes asylum seekers should be treated.

[12] *Id.*

[13] *Id.*

[14] *See* ICE Detention Standard on Medical Care, section I, *available at* http://www.ice.gov/doclib/partners/dro/opsmanual/medical.pdf.

[15] Letter from Roger Thomas, Deputy Warden, York County Prison, to Joe Sallemi, D.A.D.D., ICE, regarding DIHS, dated November 28, 2005, at p. 3.

[16] Dana Priest and Amy Goldstein, "System of Neglect," *Washington Post*, May 11, 2008.

[17] Transcript of *The Diane Rehm Show*, "Medical Care of Detained Immigrants," WAMU Radio 88.5 FM, (a National Public Radio affiliate in Washington, D.C), May 13, 2008, *available at* www.wamu.org.

[18] We understand that previously a fourth nurse reviewed requests from hospitalized detainees across the nation, but that such requests are now spread among the three remaining staff. *See*, e.g., http://www.icehealth.org/ManagedCare/ManagedCare.shtm.

[19] Dana Priest and Amy Goldstein, "In Custody, In Pain," *Washington Post*, May 12, 2008.

ommended for denial had to be reviewed by the Medical Director. As Chairwoman Lofgren described, a policy change now allows denial of requested treatment to be issued by the MCCs without review by the Medical Director. As a result, off-site nurses may deny care that was requested by on-site jail medical personnel—potentially endangering lives, and doing so with little to no oversight by doctors.

Chairwoman Lofgren described another change to DIHS policy that we find alarming. DIHS previously allowed on-site physicians or medical personnel in the ICE facilities to effectively appeal a denial of treatment by asking that the request be reviewed by three DIHS physicians, not including the Medical Director who may have previously authorized denial of treatment. While not fully independent, this process at least allowed for review by additional physicians. Chairwoman Lofgren's comments in the May 21 press conference suggest that this process has been replaced with a grievance process that no longer permits independent or even quasi-independent review.

Vigorous oversight by Congress and independent investigators must be conducted to measure the impact of these policy shifts with regard to the fairness of detainee access to treatment and the well-being of detainees. The Detainee Basic Medical Care Act corrects some of these problems by mandating that treatment decisions are based solely on professional clinical judgments and by mandating the continuity of care. These ensure that immigrant detainees are able to consistently obtain prescribed medicine that they were administered prior to entering ICE custody. Finally, the bill's establishment of an administrative appeals process for denials of medical or mental health care will help to correct the dangerous DIHS policy that is in place today.

V. NIJC'S CLIENTS HAVE BEEN ROUTINELY DENIED ADEQUATE HEALTH CARE

We all know that policies have consequences for real people. Policies that are carried out with a callous disregard for humane treatment, medical ethics, and international human rights standards lead to the horrific stories you have heard today and read in recent national press coverage.

I would like to describe briefly several specific cases that reflect the persistent problems I have seen over a dozen years.[20] The stories of these men and women illustrate the urgent need for systemic reform of the immigration detention health system to improve screening, comprehensive medical and mental health evaluations, access to medical records, and response to urgent treatment requests. Many of these problems can be addressed through enactment of the Detainee Basic Medical Care Act.

A. Inadequate Screening

Inadequate screening can fail to catch obvious medical conditions, including advanced stages of pregnancy, kidney stones, suicidal tendencies, and infectious disease. Early in my tenure at the National Immigrant Justice Center, a woman held in a county jail under contract to the INS, ICE's predecessor agency, gave birth in a jail bathroom. The INS and jail staff did not know she was pregnant. Granted, this case occurred several years ago, but little has changed. The same detention standards that were adopted by the INS in 2000 are still in place and frequently violated.

NIJC represented an Afghan asylum seeker who was detained for more than eight months in a county jail in Wisconsin. He developed kidney stones and saw the jail nursing staff repeatedly. On rare occasions, he was provided with Tylenol or ibuprofen. It took the intervention of an attorney at NIJC to obtain medical tests to diagnose his serious condition. Then, this asylum seeker was transferred to another facility unexpectedly, before the test results were available.

NIJC also represented a West African asylum seeker who suffered immeasurable harm after being kidnapped by soldiers and held for six months as a sex slave and laborer. She finally escaped her captors and reached the United States, where she was detained in a Detroit area jail. Even though she was an asylum seeker, she was held with the criminal population. She was unable to obtain adequate medical screening or access to health care, despite the fact that she suffered from pelvic pain and bleeding as a result of the torture she endured in captivity. After extensive negotiations with NIJC, the government agreed to release her. NIJC arranged for her to obtain the medical and mental health counseling she desperately needed. She eventually won asylum.

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[20] To protect client confidentiality, most of these cases are described without using the client's name. NIJC will provide this information to the Committee upon request and with client permission.

In yet another case, a female client of NIJC exhibited signs of malaria that were not recognized by jail medical staff. The woman, an asylum seeker from Rwanda, recognized the symptoms and asked for medical care. She was provided with aspirin by the jail's medical staff. NIJC attorneys intervened and educated the jail physician, who had no experience or knowledge of tropical diseases. Malaria is easily treated, but can be fatal if misidentified or treated incorrectly. NIJC eventually convinced the government to release our client.

The Detainee Basic Medical Care Act requires that each immigrant in ICE custody receive a comprehensive medical and mental health screening upon arrival at a facility, and a comprehensive examination within 14 days of arrival. It also requires that appropriate personnel have access to medical records, an important step to ensuring proper diagnosis, prescriptions, and treatment.

B. Inadequate Treatment and Deaths in Detention

In 2005, an Algerian asylum seeker, Hassiba Belbachir was detained at McHenry County Jail in Woodstock, Illinois.[21] According to the complaint filed in a civil rights and wrongful death suit brought by her estate, on March 13, 2005, Ms. Belbachir, who suffered from severe depression and panic attacks, told a nurse of her desire to take her own life. The next day, she saw a social worker and again expressed her suicidal feelings. The social worker recommended she see a psychiatrist. But rather than scheduling an emergency appointment, the nurse placed her on a list to see the psychiatrist at his routine weekly jail visit a full four days later. Ms. Belbachir committed suicide before she had an opportunity to see the psychiatrist. To make the situation even more tragic, on the day of her death, jail staff saw her lifeless body motionless on the floor of her cell in the medical pod, but did not intervene for 40 minutes, when they finally called for emergency service. By the time jail staff entered her cell, it was far too late. Her face was purple. The jail-issued knee socks knotted together and wrapped around her neck had asphyxiated her.[22]

Significantly, ICE authorities knew from annual inspections, before Ms. Belbachir's death, that McHenry County Jail had a history of failing to provide adequate mental health and suicide screenings to ICE detainees, maintained no adequate written suicide prevention policy, and failed to adequately train staff to prevent suicides. Even so, according to the Belbachir complaint, ICE authorities did not enforce the Detention Standards until after Ms. Belbachir's death.[23] Further, no one charged with overseeing her custody and care was disciplined in any matter related to this gross failure of medical and mental health care and supervision.[24]

Such tragic and preventable cases call into question ICE's ability to monitor its facilities and conduct adequate, much less vigorous, oversight of its own operations. The Detainee Basic Medical Care Act requires ICE to report any death in detention to the Offices of the Inspector General of the Department of Homeland Security and Department of Justice within 48 hours. It also mandates reporting to Congressional oversight committees. These are critical measures long overdue. Only with greater transparency will we achieve accountability.

C. Failure to Transfer Medical Records When Detainees are Moved is a Persistent and Dangerous Problem

Over the lifespan of NIJC's project to educate health care practitioners in Midwestern facilities holding ICE detainees, NIJC spoke to dozens of jail staff and asked about their experience treating detainees. A common complaint from these nurses and other personnel included widespread failure to receive medical records when detainees were transferred from one ICE facility to another. In fact, in no case did a jail guard or medical professional tell NIJC that medical records were transferred to a new facility with an incoming detainee, despite the requirement in the ICE Detention Standards that records be transferred with each detainee.[25]

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[21] The case of Hassiba Belbachir is discussed publicly because it is the subject of federal litigation. In addition, the attorneys for the Belbachir estate authorized the use of her name in this testimony

[22] Amended Complaint of the Estate of Hassiba Belbachir v. County of McHenry et al, Case 1:06-cv-01392, Filed Nov. 9, 2007 (N.D.Ill.)

[23] *Id.*

[24] *Id.*

[25] *See* ICE Detention Standard on Medical Care, section III.N., "Transfer and Release of Detainees," which states, "When a detainee is transferred to another detention facility, the detainee's medical records, or copies, will be transferred with the detainee." This standard was issued by the INS on September 20, 2000 and adopted by ICE along with the other Detention Standards when it succeeded the INS.

VI. IN ITS HASTE TO DEPORT NON-CITIZENS, ICE CUTS CORNERS AND MAKES RASH DECISIONS THAT HAVE THE POTENTIAL TO EXPOSE THE PUBLIC TO HEALTH RISKS

Last year, NIJC helped an African immigrant with infectious tuberculosis and AIDS seek much-needed medical treatment. This man was previously detained, but ICE released him on an order of supervision when it discovered he was HIV-positive. He was later diagnosed with AIDS. NIJC filed a motion for a stay of removal and expended extraordinary efforts to notify senior ICE officials that deportation would be inhumane in this case and could create a public health risk. The man was nonetheless put on a plane to Africa, an action that may have exposed other passengers to his infectious tuberculosis. NIJC strongly urges Congress to enact, and ICE to adopt, the provisions in the Detainee Basic Medical Care Act regarding continuity of care and development of discharge plans. As this case makes clear, such steps are not only critical for detainee health but also influence public safety.

VII. FOR DETAINEES WITHOUT ATTORNEYS, SEEKING MEDICAL ATTENTION CAN BE A FRUITLESS QUEST

ICE, DIHS, and congressional oversight committees must recognize that due to a chronic lack of legal counsel, most detained immigrants never know of their right to health care, much less how to exercise that right. When they do request treatment or complain about a lack of adequate care, detainees face insurmountable procedural obstacles and an accountability vacuum. A lack of transparency regarding who is detained, where, and for what purposes keeps claims related to health care and detention conditions beyond the reach of legal service providers and out of public view. Most of the stories you heard today have pierced the veil only because a lawyer, a social service provider, a volunteer with a religious organization, or a family member fought to hold the government accountable for the treatment of a particular individual in its custody. Like the cases revealed by Freedom of Information Act requests and the recent reports from *The New York Times* and the *Washington Post* cited above, they are powerful anecdotes that suggest broader violations.

NIJC legal staff members routinely advocate for clients who need medical care and who cannot obtain it in ICE detention. Complaints about access to medical care are a constant theme in our conversations with detained immigrants. These grievances range from the denial of over-the-counter pain medication to a refusal to provide life-sustaining medication for chronic illnesses. In addition to general medical conditions, NIJC has fought on behalf of asylum seekers who have been denied treatment for injuries sustained from the torture and the persecution from which they have sought refuge in the United States. Without an attorney or an advocate, these individuals would never have received appropriate care. How many other detained individuals are being denied critical medical care? How can we balance the use of detention with the humane treatment of detainees?

Considering alternatives to detention would be a good start. It is inhumane to detain asylum seekers and other immigrants who have experienced trauma or other severe medical conditions. Alternatives to detention through non-governmental and private entities are proven to be secure and effective. Under these programs, an immigrant in removal proceedings is released to participate in an "enhanced supervision" program that requires regular check-ins with a caseworker, or in some cases, the use of an electronic ankle bracelet. Alternatives are less expensive than ICE detention, which averages approximately $95 dollars per day. Alternatives also provide a wider array of medical and mental health care options. The Detainee Basic Medical Care Act recognizes this humane and common sense approach by prioritizing the parole or bond of immigration detainees who have serious medical or mental health conditions.

VIII. CONCLUSION

ICE and DIHS must provide screenings to all detainees in a timely manner and make decisions about treatment based on medical conditions, and *not* on the individual's immigration status. Providing adequate medical care is part of a broad range of detention conditions that the government must monitor and for which it must be accountable.

Accordingly, decisions about health care must be made by on-site attending medical professionals, and not by a team of bureaucrats in Washington, D.C. An appeals process must be established for the review of request denials from detainees by on-site medical professionals in detention facilities. The medical and mental health requirements, appeal process for denial of care, and increased oversight in the Detainee Basic Medical Care Act will facilitate care for all detained immigrants. In

many cases, alternatives to detention may be both the most humanitarian and fiscally responsible actions.

Like any other area of government responsibility, where lives hang in the balance, maintaining humane detention conditions will depend upon oversight, transparency and accountability.

Thank you for the opportunity to testify today. I request that my full statement be made part of the record and would be pleased to answer your questions.

Ms. LOFGREN. Thank you very much for your testimony.

Ms. Baker, we would be pleased to hear from you.

TESTIMONY OF ANN SCHOFIELD BAKER, PARTNER, McKOOL SMITH, AND ATTORNEY FOR AMINA BOOKEY MUDEY, FORMER DETAINEE

Ms. BAKER. Thank you. I am Ann Schofield Baker. I am a principal at the law firm of McKool Smith in charge of their trademark litigation practice. Thank you to Congresswoman Lofgren and this Subcommittee for inviting me to testify today.

As an intellectual property trial lawyer, I will admit I knew very little about asylum law or about the inner workings of detention centers until I agreed to represent pro bono Amina Mudey, a 29-year-old torture survivor from Somalia who sought asylum in the United States. Amina suffered unspeakable torture, abuse and loss in Somalia, as evidenced by her scars and four murdered family members.

In April of 2007, Amina fled to America and sought asylum. She was incarcerated in the Elizabeth Detention Center in New Jersey, which is run by CCA.

When I took Amina's case, I had no idea that I was destined to spend over 600 hours in the first 3 months focusing not on her asylum case but on battling DIHS, ICE and CCA to ensure that Amina didn't die in their care.

Amina has authorized me to testify before you today.

During Amina's 5-month ordeal in ICE custody, she experienced repeated incidents of medical mistreatment, incompetence and neglect that threatened her life, her health and her asylum case. In fact, there were two separate incidents in which her life was threatened because of poor medical treatment.

When Amina first arrived at the CCA, she had a panic attack and fainted. She didn't speak English at the time, and DIHS medical staff examined her without an interpreter. They wrote in her medical records that, "Patient complains that she has epilepsy and has seizures once or twice a week for 5 years." When I had the aid of an interpreter, I asked her, "What's this all about?" And she said, "I don't have epilepsy. I was trying to tell them I've had headaches once or twice a week for last 5 years."

Then detention center doctors misdiagnosed her as being psychotic. They placed her on a powerful antipsychotic drug called Risperdal that had cataclysmic side effects on her, and they are telltale side effects of Risperdal. She started to lactate. She started to drool and convulse like she had Parkinson's disease. She fell off her chair. She stopped getting a period. She started to drool. You can't miss these side effects. She became dizzy and confused.

Amina had no idea what was happening to her since no one ever gave her treatment with an interpreter. She showed the nurse that milk was coming out of her breasts, and she gave her a pregnancy

test and gave her a cup to go get a urine sample. And since she couldn't speak English, she started giving them a milk sample from her breasts.

Two weeks after this incident—it actually took 2 weeks for a doctor to evaluate her after she began to exhibit signs of lactation. What was his reaction? To increase her dosage of the Risperdal. She was still on Risperdal when I took her case 2 months later.

And I brought in two outside doctors to examine her on her underlying asylum case. Dr. Katherine Falk wrote in her sworn affidavit in the case, "The diagnosis given to her by the doctor seeing her at the detention center is post-traumatic stress disorder, psychosis and depression. There is no evidence of psychosis, and there is absolutely nothing in the notes to indicate that she had any symptoms that would lead a medical doctor to be able to diagnose psychosis. She is not psychotic and should not be taking Risperdal."

Dr. Laurie Goldstein wrote in her affidavit, "At the time of my exam of Ms. Mudey, I was alarmed at the side effects that I witnessed due to the medications she was being prescribed at the Elizabeth Detention Center. And I advised her to refuse the Risperdal."

Both doctors submitted handwritten notes to the detention center doctors explaining their credentials, explaining that they had given a full examination, that the Risperdal was wrong, "Please contact me if you want to discuss the issue."

The doctor became angry at Amina and said, "You need to keep taking this drug." Thankfully she refused, because the side effects she was exhibiting—if you go on Risperdal's Web site, they are all right there—the side effects were potentially permanent and life-threatening.

Well, about 6 weeks later, as I was trying to prepare Amina to testify during my lawyerly duties, she developed symptoms of a serious abdominal illness that required immediate medical attention, but DIHS medical professionals ignored her pleas for help for weeks. A guard threatened to throw her in the SHU, CCA's solitary confinement chamber, if she continued to request medical attention and exhibit signs of sickness.

She called me in tears, doubled over in pain, and asked me to intervene. I called the CCA and spoke to a medical professional and alerted them that she had someone inside the facility that needed to go to a hospital immediately or else I was going to call 911. And the person on the other end of the phone eventually said, "Okay, fine, we will go and look in on her and see what is wrong with her."

Amina called me back 2 days later to say that nobody had had come to see her. And I didn't call 911 because the person on the other end of the phone told me, if you call 911, we won't let them into the facility.

Well, after I found out that no one had come to see her, I prepared a Federal lawsuit to force them to take her to a hospital because I was afraid she would be dead by the end of the weekend. And the only reason they took her to a hospital is that they found out that I was going to file this complaint.

To this day, they have refused to tell me what hospital they took her to, and I don't have her medical records, and I haven't seen

medical records from her since June. I wonder why they don't want to give them to me. Can you figure it out?

This is how ICE treated a torture survivor who fled to the U.S. in search of safety. Amina and other asylum seekers simply don't have the option to just go home.

I look forward to taking your questions.

[The prepared statement of Ms. Baker follows:]

PREPARED STATEMENT OF ANN SCHOFIELD BAKER

Written Testimony Regarding Abuses in the Medical Care Provided to Immigration Detainees ©

Ann Schofield Baker, Esq.
Principal, Law Firm of McKool Smith, New York Office
Head of National Trademark Litigation Practice
***Pro Bono* Attorney for Amina Mudey, Asylee and Former Detainee of the Elizabeth Detention Center in New Jersey**

Before the House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law
Hearing on "Problems With Immigration Detainee Medical Care"

June 4, 2008

Good afternoon. My name is Ann Schofield Baker, and I am a Principal in the New York office of the national litigation law firm, McKool Smith. I am the head of McKool Smith's national trademark litigation practice, and also practice general commercial litigation in courts around the country. I am a native of Toronto, Canada, and have practiced intellectual property and commercial litigation in Washington, D.C. and New York since I graduated, *magna cum laude*, from New York Law School in 1997.

As an intellectual property trial lawyer, I knew very little about asylum law, or the inner workings of immigration detention centers, until I agreed to represent Amina Bookey Mudey, a 29-year-old torture survivor from Somalia who sought asylum after she arrived at JFK Airport on April, 11 2007. Immigration and Customs Enforcement ("ICE") officials took Ms. Mudey into custody, and incarcerated her at the Elizabeth Detention Center in New Jersey, a detention facility which is run, for profit, by Corrections Corporation of America ("CCA"). The Department of Immigration Health Services ("DIHS") is responsible for providing detainees at CCA with adequate and competent medical care. Ms. Mudey has authorized me to testify before you today.

Executive Summary

Over the course of Ms. Mudey's five month ordeal in ICE custody, she experienced repeated incidents of medical mistreatment, incompetence and neglect. For example:

(i) When she first arrived at CCA, DIHS misdiagnosed Ms. Mudey as being psychotic, and placed her on a powerful anti-psychotic drug called Risperdal that, among other side effects, caused her to lactate, drool, convulse uncontrollably, cease menstruation, become dizzy and confused, and appear as though she was developmentally disabled, when in fact, she is highly intelligent;

(ii) DIHS medical staff was well aware of Ms. Mudey's symptoms, but *increased* the dose instead of removing her from the drug, despite the fact that the side effects were potentially fatal;

(iii) Ms. Mudey developed symptoms of a serious illness that required immediate medical attention, but DIHS ignored her pleas for help for three weeks;

(iv) When I alerted DIHS medical staff by telephone that Ms. Mudey had not been seen by a doctor in weeks, that she was doubled over in pain and needed to be rushed to the hospital for a potentially life-threatening illness, they assured me that she would receive immediate medical attention - - and then failed to check on her for two more days;

(v) When I threatened to call 911 to dispatch an ambulance to CCA if DIHS would not treat Ms. Mudey immediately, the medical professional, who refused to identify herself and who eventually hung up on me, told me that if I called 911, the paramedics would not be permitted to enter the facility;

(vi) DIHS took Ms. Mudey to a hospital only *after* they learned that Ms. Mudey had consulted a lawyer and outside doctor, and on information and belief, *after* they learned that I had prepared, and was about to file, an emergency federal lawsuit to force them to take her to a hospital;

(vii) A guard threatened to lock Ms. Mudey in the "SHU," CCA's solitary confinement chamber, if she continued to request medical attention and exhibit signs of sickness;

(viii) DIHS medical staff never used a Somali interpreter in their evaluation and treatment of Ms. Mudey, even though she did not speak English, and they rejected my repeated offers to provide a Somali interpreter to them at no cost;

(ix) During her entire stay in ICE custody, Ms. Mudey was held in what is essentially a windowless, converted warehouse, and was never once permitted to set foot outside for real outdoor recreation;

(x) Although Ms. Mudey was ultimately granted asylum, and has been free for over eight months, ICE officials have refused to release Ms. Mudey's medical records to her, or to me, and to this day, have refused to identify which hospital they took her to, and what treatment was rendered to her, despite numerous requests.

Ms. Mudey's story is shocking, disturbing and, as evidenced by recent news reports, all too common. I thank Congresswoman Lofgren, Representative King and members of the Subcommittee, for inviting me to testify regarding this glaring humanitarian problem that is occurring on our own soil, and for taking an interest in issues relating to the detention of asylum seekers and other immigrants.

I would also like to thank Human Rights First ("HRF"), which is a not-for-profit organization that matches qualified asylum candidates with top law firms that accept asylum cases on a *pro bono* basis. HRF referred Ms. Mudey's case to me, and provided excellent training and support to me on her case. For that, I will always be grateful.

Finally, I would like to thank my law firm, McKool Smith, for supporting this, and other, important *pro bono* matters. When law firms represent *pro bono* clients with the same zealous advocacy with which they represent their corporate clients, they can make a significant difference. McKool Smith has established a Trust Account for Ms. Mudey to enable her to attend school for the first time in her life, and to adjust to her new life in America. For more information, please visit the following URL: http://www.mckoolsmith.com/news-40.html

Ms. Mudey Was Tortured in Somalia and Fled to America to Seek Asylum

Amina Mudey is a torture survivor. As a ten-year old girl, she suffered through the barbaric procedure known as Type III female genital mutilation, or "infibulation," which was performed with a razor blade, without anesthesia. 98% of Somali girls are subjected to this torture. To this day, Ms. Mudey continues to suffer painful consequences from her disfigurement.

In Somalia, people are born into certain clans which define their station in society. Ms. Mudey and her family were born into an "outcast" minority clan near the bottom of Somalia's clan system. With no police force or government to protect them since 1991, when rebels overthrew the Siad Barre government, majority clans have raped, murdered, tortured and robbed unarmed minority clans with impunity. The current Somali crisis has been described by many media outlets as the world's worst humanitarian crisis.

As members of a minority clan, Ms. Mudey's family has been subjected to years of abuse and unspeakable violence by majority clan members. When armed men stormed her family's home, Ms. Mudey escaped out the back door, and heard the gunshots that killed her father and two brothers as she ran for her life. Ms. Mudey and her mother were forced to watch as Ms. Mudey's sister was raped by five men, and then shot to death because she would not stop screaming. The perpetrators beat Ms. Mudey severely, smashed her head with the butt of a gun, and left her for dead. Members of a majority clan threw boiling hot oil at Ms. Mudey's face in an attempt to disfigure her. The oil missed her face, but burned her neck severely, leaving a large, permanent scar. With no police force or government in place, none of these atrocities have been investigated, and the perpetrators remain at-large.

In 2006, Ms. Mudey's mother raised $2500 by selling her only possession, the family home, so that Ms. Mudey could flee to America. Ms. Mudey's mother and siblings are now homeless, and are living in a Somali refugee camp close to the Kenyan border. When she arrived in the United States, Ms. Mudey was detained, as are all asylum seekers who arrive on false or invalid documents. She was incarcerated at the Elizabeth Detention Center in New Jersey pending a hearing on her petition for asylum.

DIHS Misdiagnosed Ms. Mudey as Psychotic and Prescribed a Drug That Had Life-Threatening Side Effects - - Which Medical Staff Ignored

Soon after Ms. Mudey was brought to CCA, shackled, exhausted and malnourished, Ms. Mudey had a panic attack and fainted. She did not speak English, and could not communicate without an interpreter. A DIHS doctor, who "examined" Ms. Mudey without a Somali interpreter, misdiagnosed her as being psychotic, and put her on a potent anti-psychotic drug called Risperdal.

The drug, which Ms. Mudey did not need, caused her to experience devastating and life-threatening side effects. Ms. Mudey began to shake uncontrollably, as though she had Parkinson's disease. She started to lactate. She stopped having a menstrual period. She vomited regularly. She was unable to close her mouth, and her tongue thrashed in her mouth involuntarily. She often drooled. She became dizzy, disoriented and confused.

She had difficulty walking, and sometimes fell off her chair. The drug made Ms. Mudey seem as though she was developmentally disabled, when in reality, she is highly intelligent. These symptoms are well-documented side effects of Risperdal.

DIHS medical staff was well aware of Ms. Mudey's symptoms. Indeed, when Ms. Mudey showed the medical staff that milk was coming out of her breasts, they administered a pregnancy test (which, of course, was negative), and sent her back to her room without further treatment. After this incident, rather than take her off the drug, the doctor *increased* the dosage of Risperdal. Moreover, DIHS never told Ms. Mudey what drug they were administering to her, nor did they explain its side effects. Consequently, Ms. Mudey had no idea what was causing the dramatic and frightening changes to her mind and body. She felt as though she was dying.

While Ms. Mudey's mental capacity was diminished, and while she was losing control of her body's movements, she was forced to wade her way through the legal asylum process alone. No one explained to Ms. Mudey what the asylum process would entail. Ms. Mudey found the phone number for Human Rights First scribbled on the detention center wall by a former Somali detainee, and contacted them to ask that they find her a lawyer. HRF interviewed Ms. Mudey with a Somali interpreter, and began to search for a *pro bono* attorney.

In the meantime, at the height of the Risperdal's debilitating and mind-altering side effects, government officials placed Ms. Mudey under oath, *twice*, without a lawyer, never informed her that she had the right to a lawyer, and questioned her repeatedly. Ms. Mudey's asylum application was at stake. If she lost, she could have been returned to Somalia where she would have been killed.

Ms. Mudey Found a Pro Bono Lawyer

In mid-June, 2007, Ms. Mudey's case was referred to me through HRF. Although I am an experienced commercial litigator, this was my first asylum case. At the time I took her case, Ms. Mudey had been in ICE custody for two months.

Soon after I took the case, I attended an HRF training seminar on immigration law and procedure, reviewed Ms. Mudey's file and conducted my first interview of Ms. Mudey in the lawyer's examination room of the CCA. At that time, I observed many of the symptoms which I now know to be the side effects of Risperdal.

On June 12, 2007, I represented Ms. Mudey at a court hearing before an immigration judge. The judge ordered that I prepare and file Ms. Mudey's asylum petition within sixteen days. I have since learned that preparing an asylum petition usually takes a team of lawyers 4-6 weeks to prepare.

In those first sixteen days, I had to: secure a Somali interpreter, since Ms. Mudey did not speak English; find and convince two *pro bono* doctors to examine Ms. Mudey at CCA to evaluate her underlying asylum claim; somehow extricate country-issued identity documents from Ms. Mudey's mother, who was last known to be living in a Somali refugee camp without a mobile phone or internet access; uncover from Ms. Mudey the story of her life and the facts on which her asylum claim would be based; and prepare her

affidavit and asylum application. I managed to accomplish all of these tasks within sixteen days, but in the process, learned that Ms. Mudey's situation was far more serious than I could have imagined. Little did I know that I was destined to devote over 600 hours to Ms. Mudey's case in the three months that followed, and that a large number of those hours would be focused not on her asylum case, but on battling DIHS, ICE and CCA to ensure that she did not die in their care.

Two Independent Doctors Determined that DIHS Doctors Had Misdiagnosed Ms. Mudey and that She Was Suffering Severe Side Effects from the Risperdal

Within a week of taking the case, I arranged for Dr. Laurie Goldstein, a respected gynecologist with more than twenty five years of experience, and Dr. Katherine Falk, a noted psychiatrist with more than thirty years of experience, to examine Ms. Mudey at CCA, with a Somali interpreter. Dr. Falk examined Ms. Mudey on June 24, 2007, and Dr. Goldstein examined Ms. Mudey on June 25. Both doctors took a full medical history of Ms. Mudey, and interviewed her regarding her experiences in Somalia. In addition, Dr. Goldstein performed a full physical and gynecologic exam. ICE provided me with a copy of Ms. Mudey's detention center medical records through June 25, 2007, and both doctors reviewed the records before preparing affidavits in the case. Relevant portions of Dr. Falk's June 27, 2007 affidavit and Dr. Goldstein's July 6, 2007 affidavit are attached to my testimony as **Exhibits 1 and 2**, respectively. ICE has refused to provide either Ms. Mudey or me with a copy of her medical records since June 25, 2007, despite repeated requests.

The medical records are replete with errors and miscommunications due to the fact that DIHS staff evaluated and treated Ms. Mudey without an interpreter. For example, on April 12, 2007, a nurse wrote in Ms. Mudey's records that Ms. Mudey "reports hx of Epilepsy x 5 years, has seizure 1-2 times/weekly." When Ms. Mudey reviewed this record with the aid of an interpreter, she indicated that she was *trying* to tell the nurse that she has experienced *headaches* for more than five years. She has never had epilepsy.

Another major miscommunication is evident on April 23, 2007, when the records indicate:

> Pt [Ms. Mudey] brought to medical by CCA supervisor. Pt states she is probably pregnant. C/O breast tenderness and discharge. States she is nauseated and cannot eat. . . . . Instructed to go into the bathroom and supply a urine sample. After a long period of time Nurse checked on the Detainee to find her squeezing her breasts and nipples. . . . Pregnancy test is negative. Pt has document HX of PTSD [Post Traumatic Stress Disorder] and? seizures vs. hysteria . . . Pt education regarding avoidance of squeezing breast tissue and surrounding area. Refer to sick call for follow up."

Ms. Mudey went to DIHS on April 23 to seek treatment because her breasts began to produce milk. When the nurse provided her with a cup, and instructed her to give a urine sample, she thought the nurse was asking her to give a breast milk sample. She did not understand the nurse's directions because the nurse did not use an interpreter to communicate with Ms. Mudey. Ms. Mudey went to the bathroom and proceeded to fill

the cup with breast milk. When the nurse discovered what Ms. Mudey was doing, she scolded Ms. Mudey, and made clear that it was a urine sample she wanted.

The claim that Ms. Mudey told DIHS that she was "probably pregnant" is pure fiction. Ms. Mudey, who is a religious woman, knew full well that she could not possibly be pregnant, and made no such statement.

After the nurse documented that Ms. Mudey was lactating, Ms. Mudey was not seen again by a physician until May 4, 2007. His instruction was to "increase Risperdal." DIHS staff complied.

Both Drs. Falk and Goldstein observed that Ms. Mudey was experiencing severe side effects from the Risperdal, that Ms. Mudey was misdiagnosed as being psychotic, and that nothing in her records could have supported DIHS' determination that Ms. Mudey was psychotic. Dr. Goldstein stated that:

> In my history taking, I found no history of psychotic behavior or seizure disorder. Ms. Mudey clearly describes a syncopal episode (fainting) after her arrest, which was due to fatigue, hunger and fear. Often, patients will shake after such an episode, and this may look like a seizure, but it is not.
>
> * * *
>
> On physical exam, Ms. Mudey, is a light-skinned black female. Initially, she appears dull or drugged, with a shuffling gait, unblinking eyes, and a drooping lower lip. She makes continuous little tongue-thrusting movements in her mouth, and has restless legs which she cannot control. These symptoms are all consistent with extrapyramidal side effects that can occur with anti-psychotic medication.
>
> * * *
>
> On examination of the breasts, there is very obvious galactorrhea (milk produced, and elicited at the nipples.) In addition, the breasts are full and tender. A pregnancy test done at the center was negative. It is well documented that Risperdal, the anti-psychotic medication that she is currently taking, can cause galactorrhea, and amenorrhea (absence of the menstrual period). Her lack of a period, breast tenderness, and milk production are all side effects of the mediation.
>
> * * *
>
> At the time of my exam of Ms. Mudey, I was alarmed at the side effects that I witnessed due to the medications she was being prescribed at the Elizabeth Detention Center, and I advised her to refuse the Risperdal, and request medications specific for sleep or anxiety if she needs them.

(Exhibit 2 - Goldstein Aff. ¶16, 19, 21, 25).

Similarly, Dr. Falk observed that:

> She has developed nausea and vomiting and abdominal pain since being in the detention center. She has never had this kind of abdominal pain or these symptoms when she lived in Somalia. . . .
>
> She has not had her period in two months.
>
> Her tongue and mouth are extremely dry. Her blink reflex is diminished. At times, she has abnormal uncontrollable movements in her legs. This pattern of symptoms of dry mouth, diminished blink reflex, abnormal movements and amenorrhea is consistent with the side effects of antipsychotic medication.
>
> Soon after arriving at the detention center, she had what was apparently a panic attack and was evaluated at an emergency room.
>
> * * *
>
> The diagnosis given to her by the doctor seeing her at the detention center is PTSD, psychosis and depression. She clearly has very severe PTSD and she is clearly depressed, but there is no evidence of psychosis, and there is absolutely nothing in the notes to indicate that she had any symptoms that would lead a medical doctor to be able to diagnosis psychosis. Psychosis can only be diagnosed if there is evidence that the individual is unable to test reality, i.e., unable to distinguish fantasy from reality. There is no evidence in the medical notes that this is the case. In addition, Ms. Mudey is able to make direct eye contact, which is not consistent with a psychotic diagnosis. . . She is not psychotic and should not be taking Risperdal.

(Exhibit 1 - Falk Aff. ¶32-35, 44-45).

When they concluded their examinations of Ms. Mudey, both Drs. Falk and Goldstein wrote detailed letters to DIHS medical staff that outlined their determination that Ms. Mudey was not psychotic, that she was suffering severe side effects from the anti-psychotic medication, and that the medication should be stopped. They wrote these letters by hand because CCA does not allow computers inside the detention facility. Ms. Mudey delivered these letters to the doctor who had been treating her, because the DIHS doctors usually do not accept correspondence from outside lawyers or doctors.

Ms. Mudey reported to me, and later to Dr. Goldstein, that the doctor was very angry with her when she provided the Drs. Goldstein and Falk letters to him. She reported that the doctor told her to continue taking the Risperdal. Ms. Mudey told us that the doctor said something like, "I am your doctor, your lawyer is not your doctor." Ms. Mudey understood the English words for "doctor" and "lawyer," and understood the doctor's sentiments through his body language. (Months later, the DIHS doctor returned Dr. Goldstein's note to Ms. Mudey, along with other letters that I had written on her behalf, and told her to tell her lawyer to stop sending him notes. Dr. Falk's letter was never returned.) The hand-written letter that Dr. Goldstein wrote to the DIHS doctor on June 25, 2007 is attached as **Exhibit 3**.

Thankfully, on the advice of both outside doctors, Ms. Mudey refused the Risperdal. According to information provided on Risperdal's own website, the side effects that Ms. Mudey experienced could have been fatal, or could have persisted for the rest of her life. I downloaded the following text from Risperdal's homepage at http://www.risperdal.com/risperdal/ on June 1, 2008:

> The most common adverse reactions observed in all clinical trials with RISPERDAL occurring at a rate of at least 10% were somnolence, increased appetite, fatigue, rhinitis, upper respiratory tract infection, vomiting, coughing, urinary incontinence, increased saliva, constipation, fever, tremors, muscle stiffness, abdominal pain, anxiety, nausea, dizziness, dry mouth, rash, restlessness, and indigestion.
>
> Neuroleptic Malignant Syndrome (NMS) is a rare and potentially fatal side effect reported with RISPERDAL and similar medicines. Call your doctor immediately if the person being treated develops symptoms such as high fever; stiff muscles; shaking; confusion; sweating; changes in pulse, heart rate, or blood pressure; or muscle pain and weakness. Treatment should be stopped if the person being treated has NMS.
>
> Tardive Dyskinesia (TD) is a serious, sometimes permanent side effect reported with RISPERDAL and similar medications. TD includes uncontrollable movements of the face, tongue, and other parts of the body. The risk of developing TD and the chance that it will become permanent is thought to increase with the length of therapy and the overall dose taken by the patient. This condition can develop after a brief period of therapy at low doses, although this is much less common. There is no known treatment for TD, but it may go away partially or completely if therapy is stopped.
>
> RISPERDAL and similar medications can raise the blood levels of a hormone known as prolactin, causing a condition known as hyperprolactinemia. Blood levels of prolactin remain elevated with continued use. Some side effects seen with these medications include the absence of a menstrual period; breasts producing milk; the development of breasts by males; and the inability to achieve an erection. The connection between prolactin levels and side effects is unknown.

It is clear that DHS staff misdiagnosed Ms. Mudey as being psychotic, and that they should never have prescribed Risperdal. Moreover, DHS staff either failed to recognize *any* of the well-documented, adverse side effects of Risperdal that Ms. Mudey exhibited, or worse, they *did*

recognize the side effects, but jeopardized Ms. Mudey's life by continuing to prescribe the drug - - and continuing to increase the dose - - in spite of its catastrophic side effects.

Ms. Mudey Developed Symptoms of a Serious Illness which DIHS Ignored for Three Weeks

During the last week of July, 2007, Ms. Mudey experienced constant abdominal and back pain, and pain during urination. When this pain persisted for more than a few days, she brought it to the attention of her detention center doctor, who would not provide his name. On or about Friday, August 3, 2007, Ms. Mudey saw the doctor, and tried to describe her symptoms. (As I noted above, communication between Ms. Mudey and DIHS staff was extremely difficult, since they refused to use a Somali interpreter, even though I offered numerous times to provide one at no cost.) Ms. Mudey's doctor performed no tests, conducted no physical examination, and informed Ms. Mudey that he had no idea what was causing her pain. He dismissed her without treatment.

When Ms. Mudey's symptoms continued to worsen, she filled out several medical request forms to have the doctor examine her. Apparently, the only way that a detainee can see a doctor at CCA, even during a medical emergency, is to fill out a request slip and place it in a designated box. The doctor did not respond, and did not examine Ms. Mudey. Instead, he sent a nurse to administer Diflucan, which is a medication to treat yeast infections.

Ms. Mudey's condition deteriorated rapidly, and became acute over the weekend of August 11-12, 2007. On a daily basis, starting as early as Saturday, August 11, she filled out the medical request form and placed it in the designated box. Her fellow detainees also filled out the form on her behalf. Ms. Mudey informed the nurse who administered her medication at night that she needed to see a doctor to address her intense pain, and she communicated the same to several CCA guards. All of them simply told her to fill out the request slip, and put it in the box. One of the guards threatened to throw Ms. Mudey in the "SHU," if she continued to complain about her pain.

On Tuesday, August 14, 2007, Ms. Mudey was in so much pain that she called me in tears, and asked me to intervene. She became too weak to hold the phone, and transferred the phone to another detainee, who told me that Ms. Mudey was doubled over in pain. I conferred with Dr. Goldstein briefly, and we agreed that Ms. Mudey needed to go to a hospital right away.

I called CCA, and I spoke with a female deportation officer, whom I did not know, and described the situation. Ms. Mudey's deportation officer was not working that day. After much debate, the officer transferred my call to a member of the medical staff, who was also female. They both refused to provide their name to me.

I informed the medical professional that Ms. Mudey had not been seen by a doctor in weeks, that she was doubled over in pain, and that she needed to be rushed to the hospital for a potentially life-threatening illness. The medical professional seemed to be far more interested in having me divulge the name of the person who had transferred my call to the medical department, since they do not take calls from attorneys.

I threatened to call 911 to dispatch an ambulance to CCA if DIHS would not treat Ms. Mudey immediately. The medical professional told me that if I called 911, the paramedics would not be permitted to enter the facility. After much debate, the medical professional assured me that Ms. Mudey would receive immediate medical attention, and then hung up on me. I informed Ms. Mudey that someone was on their way to see her.

Two days later, Ms. Mudey called me back to tell me that *nobody* had come to see her since our last phone call. She was still in tears, and was still doubled over in pain. A colleague of mine at the time, Adam Perlin, and I placed a barrage of telephone calls to CCA, which resulted in a new doctor paying Ms. Mudey a visit. However, the doctor conducted no physical examination of any kind, and simply gave her an aspirin. He took her blood pressure, and performed a urine test which was apparently "inconclusive." He did not take a history of the present illness, nor did he take her temperature, perform a physical exam, palpate her abdomen, or order a urine culture. Accordingly, the doctor failed to treat Ms. Mudey appropriately.

On the evening of Thursday, August 16, 2007, Dr. Goldstein interviewed Ms. Mudey about her medical condition over the telephone, at length, with a Somali interpreter. I participated in that conversation. Dr. Goldstein reaffirmed that Ms. Mudey was in need of immediate medical attention at a hospital, and that her condition was potentially life threatening.

Accordingly, I started to prepare an emergency Habeas Corpus Complaint, a federal lawsuit that sought to force DIHS, ICE and CCA to take Ms. Mudey to a hospital within hours of filing the lawsuit. I was afraid that Ms. Mudey could die by Monday without proper medical intervention.

Dr. Goldstein dictated, letter by letter, a short note that Ms. Mudey copied down in English, and instructed her to present the note to the next doctor who treated her. The note said something like: "Do I have U.T.I? Do I have P.I.D? Do I have pyelonephritis? I need an interpreter. Call [name of interpreter] at [her phone number]. My lawyer will pay for it."

I pulled an "all-nighter" and with Mr. Perlin's help, drafted a Memorandum of Law, a Proposed Order, an Order to Show Cause, and a Habeas Corpus Complaint in which I named everyone from Micheal Chertoff to Charlotte Collins, Warden of CCA, as defendants. In furtherance of the emergency lawsuit, Dr. Goldstein signed a declaration that recounted the events above, and provided her analysis of the medical situation. Dr. Goldstein's August 17, 2007 Declaration (relevant portions) is attached as **Exhibit 4**.

In her Declaration, Dr. Goldstein stated:

> She has been experiencing increasingly severe lower abdominal pain, back pain, chills, vaginal discharge, and severe pain during urination, for three weeks. She has been unable to eat or sleep for days. During much of my interview, Ms. Mudey was in so much pain that she was in tears. Based on the severe symptoms that she is exhibiting, the lack of appropriate response from the medical staff at the Detention Center, and on my

> observation of inappropriate medical care rendered to Ms. Mudey at the Detention Center over the past several months, I believe that Ms. Mudey is in need of immediate medical attention at a hospital.
>
> * * *
>
> A full medical examination needs to be conducted immediately to determine the source(s) of Ms. Mudey's illness. This examination needs to be conducted with a Somali interpreter present (or via the telephone) so that the doctor and Ms. Mudey can communicate effectively with each other.
>
> Ms. Mudey is suffering needlessly with intensely painful symptoms. If left untreated, these infections can cause serious complications, and in severe cases, even death.
>
> * * *
>
> In light of the way that the medical doctors at the Detention Center ignored Ms. Mudey's constant pleas for medical attention for almost two weeks, and the substandard care that she received yesterday, I do not believe that Ms. Mudey has received, or will receive, adequate, basic medical attention from the Detention Center medical staff. I recommend that she be taken to a local hospital immediately for a thorough examination, and that a Somali interpreter be present for this, and all future medical treatments, if needed.

(Exhibit 4 - Goldstein Dec. ¶2, 13-14, 25).

DIHS Took Ms. Mudey to a Hospital Only After They Learned that Ms. Mudey Had Spoken with Her Attorney, and that I Had Prepared, and Was About to File, an Emergency Federal Lawsuit to Force Them to Do So

On Friday, August 17, 2007, as I waited for the office staff to format, photocopy and velobind the Habeas papers, my office called the U.S. Attorney's office in Newark, New Jersey to alert them that I was about to file the emergency lawsuit, and that I intended to argue it that very afternoon. I wanted to ensure that an Assistant U.S. Attorney was aware that the lawsuit was about to be filed so that someone would be available to argue it before the weekend.

As I was about to walk out the door to file the lawsuit, Ms. Mudey called me with surprising news. (The interpreter was in my office at the time, so we were able to communicate.) Ms. Mudey told me that she had been seen by a doctor, that she had provided to him the note that Dr. Goldstein had dictated, and that she conveyed that the note was from her outside doctor and her lawyer. At some point thereafter, Ms. Mudey was informed that she was going to be taken to a hospital that very afternoon. I suspect that the U.S. Attorney's office called the CCA to tell them about the lawsuit, and to suggest that they take Ms. Mudey to a hospital.

Since I had apparently received the relief that I was seeking in the Habeas Complaint, namely, that Ms. Mudey be taken to a hospital, I did not file the lawsuit.

ICE Has Refused to Release Ms. Mudey's Medical Records and Has Refused to Identify Which Hospital She Was Taken To

I visited with Ms. Mudey on Monday, August 20. She told me that she was taken to a hospital the previous Friday, and that doctors at the hospital ran several tests, hooked her up to an I.V., and gave her an injection of some sort. She could not relay to me all that happened because, again, she was treated without an interpreter.

After Ms. Mudey returned from the hospital, she slept for most of the weekend. By the time I saw her on Monday, she was weak, but was starting to feel better. She said that she had asked for a copy of her medical records, but CCA and DIHS refused.

While I was at CCA on August 20, I hand-wrote two letters to Ms. Mudey's doctors on her behalf. One letter said:

> I wish to see my medical records to identify which hospital I was taken to on Friday, August 17, 2007. I am entitled to have access to my own medical records, and am entitled to know the names of each doctor who has administered medical care to me.
>
> As you know, I do not speak English. I speak Somali. I need to have a Somali interpreter with me, or on the phone, when I speak with doctors. My attorney has offered, and continues to offer, the services of a Somali interpreter at no cost to the government. I am being denied access to proper medical care when I cannot communicate with my doctors, especially when I am willing and able to provide an interpreter for free. . . . . This letter was written by my attorney, and was read to me in Somali by my interpreter.

The other letter complained that Ms. Mudey was not being given pain medication to take as needed, as other detainees were. These two letters are attached as **Exhibit 5**.

The Inadequate Medical Care that DIHS Rendered to Ms. Mudey Affected Not Only Her Life and Health, but Jeopardized Her Asylum Case

As I mentioned earlier, I devoted over 600 hours to Ms. Mudey's case in the three months that lead up to her final asylum hearing. I spent hundreds of those hours fighting DIHS, ICE and CCA to ensure that my client would not die in their care. My primary responsibility was to prepare Ms. Mudey's legal case for asylum, to prepare her to testify and to prepare her to be cross examined by a trained Department of Homeland Security attorney. Hundreds of hours of my time, and Ms. Mudey's precious energy, were diverted to wrangling over her medical care. I shudder to think of what would have happened to her if HRF had not found her a lawyer. Thankfully, Ms. Mudey proceeded to win her asylum hearing on September 18, 2007, and was released the same night.

Conclusion

Ms. Mudey came to this country to escape the abuse she endured in Somalia, but traded one kind of abuse for another - - at the hands of ICE, CCA and DIHS officials. She suffered needlessly. However, in light of the dozens of detainees who have tragically died in custody, we are grateful that our story has a relatively happy ending. In particular, Ms. Mudey is extremely grateful that the U.S. granted asylum to her, and to others who have fled persecution. She has been studying English full-time since her release, and hopes to become a nurse one day.

Recommendations

- That detainees receive the right to an interpreter when speaking with their doctors.
- That detainees receive the right to real outdoor recreation at least as much as inmates do.
- That detainees receive access to their medical records upon request.
- That Congress mandate greater oversight of the medical staff who provide care to detainees to ensure that they are competent and qualified.
- That Congress consider appointing public defenders to represent asylum candidates who have no legal representation.
- That Congress examine and overhaul the system for paroling or releasing immigration detainees to ensure that those who satisfy the criteria for release (including, of course, that they present no risk and will appear for their immigration proceedings) do not spend months, or longer, in prison-like facilities, and are released to a monitored parole process or supervised release program.
- That Congress examine and overhaul legal proceedings in asylum cases along with its overhaul of medical treatment provided to detainees. I was almost as shocked by the legal system as I was by the medical care provided to my client. For example, asylum seekers have no right to discovery in Immigration Court, and routinely see relevant documents for the first time at trial. Also, I brought a Somali interpreter to Ms. Mudey's trial to allow me to communicate with her during the proceedings, but *CCA officials* escorted her out of the building citing a *CCA* policy that interpreters are not allowed in the courtroom. Since the immigration courtrooms are located inside the CCA facility, the Immigration Judge said that she was powerless to defy the CCA rule against allowing my interpreter to stay. Accordingly, I was unable to communicate with my own client during her asylum trial, unless I used the government's interpreter.

Ann Schofield Baker, Esq.

Before the House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law Hearing on "Problems With Immigration Detainee Medical Care"

June 4, 2008

Exhibit 1

UNITED STATES DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
OFFICE OF THE IMMIGRATION JUDGE

In the Matter of	:	In Removal Proceedings
Amina Bookey Mudey	:	**AFFIDAVIT OF**
	:	**KATHERINE FALK, M.D.**
File No. A 97 533 835	:	

STATE OF NEW YORK)
) ss:
COUNTY OF NEW YORK)

KATHERINE FALK, M.D., being duly sworn, states:

I submit this affidavit in support of Amina Bookey Mudey's request for asylum.

PROFESSIONAL QUALIFICATIONS:

1. I am a physician licensed in the State of New York, specializing in Psychiatry (license #111851.) I graduated from the Mount Sinai School of Medicine in 1970. I completed an internship and assistant residency in Internal Medicine in 1972 and a residency in Psychiatry in 1975, all at the St. Luke's Hospital Center in New York City. I am a psychiatrist and board certified in Psychiatry (Diplomate of the American Boards of Psychiatry and Neurology 1977). I have been in private practice since 1975.

2. In 1985, I founded the Project for Psychiatric Outreach to the Homeless, Inc, a not-for-profit organization which provides psychiatric services to mentally ill homeless adults, children and families throughout New York City. I worked with this organization for 18 years, serving as the President of the Board and also as the Medical Director. I resigned in April, 2003.

3. I am a Distinguished Life Fellow of the American Psychiatry Association. I was awarded the 1993 Exemplary Psychiatrist Award by the National Alliance for the Mentally Ill. In 2001, I was awarded The Good Neighbor Award, given by Goddard Riverside Community Center "in recognition of extraordinary deeds in helping to build a better community."

Ann Schofield Baker, Esq.
June 4, 2008 Detainee Hearing
Exhibit 1

4. From 1981 – 2005, I was an Attending Psychiatrist at the New York Presbyterian Hospital, and an Assistant Clinical Professor of Psychiatry at the Columbia University College of Physicians and Surgeons, where I taught medical students and supervised Fellows in Public Psychiatry and Residents in Psychiatry. I am now Attending Psychiatrist at the Mt Sinai Medical Center, and an Assistant Clinical Professor of Psychiatry at the Mt Sinai School of Medicine.

5. Since 1996, I have evaluated a number of individuals for Physicians for Human Rights. In my work with the homeless population in New York City and also in my private practice of Psychiatry, I have worked with diverse populations, including persons who have been victims of torture and those who have been victims of trauma other than torture.

6. I have been previously qualified in Immigration Court as an expert witness in evaluating and treating survivors of torture.

7. My curriculum vitae is attached as Exhibit 1.

8. I have provided my services for this asylum evaluation free of charge.

CLINICAL INTERVIEW OF AMINA BOOKEY MUDEY:

9. On June 24, 2007, I conducted a detailed clinical interview and comprehensive psychiatric evaluation of Amina Bookey Mudey for the purpose of evaluating the effects of the persecution and torture she reports having experienced in Somalia. The interview was conducted at the Elizabeth Detention Center, Elizabeth, New Jersey, with the assistance of , who acted as interpreter. Also present were , a third year medical student at Mount Sinai School of Medicine in New York City and Ms Mudey's lawyer, Ann Schofield. I have also thoroughly reviewed Ms. Mudey's form I-589 asylum application.

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32. She has developed nausea and vomiting and abdominal pain since being in the detention center. She never had this kind of abdominal pain or these symptoms when she lived in

Somalia.

33. She has not had her period in two months.

34. Her tongue and mouth are extremely dry. Her blink reflex is diminished. At times she has abnormal uncontrollable movements of her legs. This pattern of symptoms of dry mouth, diminished blink reflex, abnormal movements and amenorrhea, is consistent with the side effects of antipsychotic medication.

35. Soon after arriving at the detention center, she had what was apparently a panic attack and was evaluated at an emergency room.

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43. As of June 22, 2007, she is taking risperdal 2mg at bedtime and desipramine 20mg at night.

44. The diagnosis given to her by the doctor seeing her at the detention center is PTSD, psychosis and depression. She clearly has very severe PTSD and she is clearly depressed, but there is no evidence of psychosis, and there is absolutely nothing in the notes to indicate that she had any symptoms that would lead a medical doctor to be able to diagnosis psychosis. Psychosis can only be diagnosed if there is evidence that the individual is unable to test reality, ie, unable to distinguish fantasy from reality. There is no evidence in the medical notes that this is the case. In addition, Ms. Mudey is able to make direct eye contact, which is not consistent with a psychotic diagnosis.

45. She is not psychotic and should not be taking risperdal.

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60. Furthermore, it is my medical opinion that Ms. Mudey does not suffer from a psychotic illness and that the medication that she is getting is not medically indicated. The risperdal should be stopped.

61.

I declare under penalty of perjury that the foregoing is true and correct.

Katherine Falk, M.D.
Katherine Falk, M.D.

SWORN TO BEFORE ME

this 27th day of June, 20 07.
New York, New York

Katherine Falk, MD
Katherine Falk, M.D.

Notary Public: _____

NOELIA MARRERO
Notary Public, State of New York
No. 01MA6152541
Qualified in Manhattan County
Commission Expires Sept. 18, 20__

NOELIA MARRERO
Notary Public, State of New York
No. 01MA6152541
Qualified in Manhattan County
Commission Expires Sept. 18, 20__

Ann Schofield Baker, Esq.

Before the House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law Hearing on "Problems With Immigration Detainee Medical Care"

June 4, 2008

Exhibit 2

U.S. DEPARTMENT OF JUSTICE
EXECUTIVE OFFICE FOR IMMIGRATION REVIEW
IMMIGRATION COURT
ELIZABETH, NEW JERSEY

In the Matter of	)	In Removal / Asylum Proceedings
Amina Bookey Mudey	)	**Affidavit of Laurie R. Goldstein M.D.**
File No. A 97 533 835	)	

STATE OF NEW YORK)
) **ss:**
COUNTY OF NEW YORK)

LAURIE R. GOLDSTEIN M.D., being duly sworn, states:

1. I am a licensed physician in the State of New York, and a Board Certified Obstetrician-Gynecologist ("Ob-Gyn"). I am an Assistant Attending Physician at the Mt. Sinai Hospital of New York, and a Clinical Instructor at the Mt. Sinai School of Medicine. I have had experience with torture victims through more than 10 years of voluntary service for Physicians for Human Rights, in their Torture and Asylum Network. In addition, I have examined and treated torture, abuse, and rape victims during the time I practiced as a physician in Central America and as an Ob-Gyn working in the Emergency Departments of New York City Hospitals since 1978. My resume is attached as Exhibit1.

2. On June 25, 2007, under the auspices of Physicians for Human Rights, I interviewed and examined Ms. Amina Bookey Mudey, at the Elizabeth (CAA) Detention Facility in Elizabeth, New Jersey, on a pro-bono basis. A translator, , was present for the interview and physical exam. Ms. Abdi translated my questions into Somali, and she translated Ms. Mudey's responses into English.

3. On June 25, 2007, I took a full medical history of Ms. Mudey and interviewed her regarding her experiences in her home country of Somalia. I performed a full physical and gynecologic exam. I reviewed a summary of Ms.Mudey's I-589 application. In addition, I reviewed the summary of medical treatment Ms. Mudey received through the medical clinic at the detention facility, attached as Exhibit 2. The following is based on my own understanding of the information relevant to Ms. Mudey's asylum application, based on the information that I gleaned during my examination of her.

4.

Ann Schofield Baker, Esq.
June 4, 2008 Detainee Hearing
Exhibit 2

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In my history taking, I found no history of psychotic behavior or seizure disorder.
Ms Mudey clearly describes a syncopal episode (fainting) after her arrest, which was due to fatigue, hunger, and fear. Often patients will shake after such an episode, and this may look like a seizure, but is not.

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18.

19. EXAM: On physical exam, Ms. Mudey is a light-skinned, black female. Initially, she appears dull, or drugged, with a shuffling gait, unblinking eyes, and a drooping lower lip. She makes continuous little tongue-thrusting movements in her mouth, and has restless legs which she cannot control. These symptoms are all consistent with extrapyramidal side effects that can occur with anti-psychotic medication.

20.

21. On examination of the breasts, there is very obvious galactorrhea (milk produced, and elicited at the nipples). In addition, the breasts are full and tender. A pregnancy test done at the center was negative. It is a well documented that Risperdal, the anti-psychotic medicine that she is currently taking, can cause galactorrhea, and amenorrhea (absence of the menstrual period). Her lack of a period, breast tenderness, and milk production are all side effects of her medication.

22.

22.

23.

24.

25. At the time of my exam of Ms. Mudey, I was alarmed at the side effects that I witnessed due to the medications she was being prescribed at the Elizabeth Detention Center, and I advised her to refuse the Risperdal, and request medications specific for sleep or anxiety if she needed them.

I am willing to answer any additional questions, or further explain my findings.

Laurie R. Goldstein M.D., FACOG

7/6/07
Date

Sworn to before me this
6th day of July, 2007

Margaret S. Leibowitz
Notary Public, NYS

#02LE4676265
New York County
expires 10/31/2010

Ann Schofield Baker, Esq.

Before the House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law Hearing on "Problems With Immigration Detainee Medical Care"

June 4, 2008

Exhibit 3

FROM
LAURIE R GOLDSTEIN MD
(212).
MD Lic #

UTAH MEDICAL PRODUCTS INC.

Attn: Physician @ Medical Clinic Deaconess Center
Elizabeth, NJ

Re: ALMINA BOOKER MUNDAY
AKA: SHARIFA ABDI
File: A097-533-835

I am a Board Certified OB-GYN who examined Ms. Munday this morning for her asylum application.

I understand that Ms. Munday has been receiving - Desipramine 20 mg HS
- Risperdal 1 mg @ Noon
2 mg @ HS

During my exam I found that the patient has significant extrapyramidal side effects from the Risperdal - and other serious side effects, including Amenorrhea + Galactorrhea. In addition, I can elicit no history of psychotic ideation or behavior and I see no indication to continue the pt. on this drug.

I have recommended to Ms. Munday that she stop taking Risperdal, but continue with desipramine.

In addition I would recommend that if she has trouble sleeping, that she be prescribed either Ambien or Klonopin (or any benzodiazepine) if she is anxious.

Thank you - feel free to call me.

(801) 566-1200 • TOLL FREE (800) 533-4984 • FAX (
7043 SOUTH 300 WEST • MIDVALE, UTAH

Ann Schofield Baker, Esq.

Before the House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law Hearing on "Problems With Immigration Detainee Medical Care"

June 4, 2008

Exhibit 4

UNITED STATES DISTRICT COURT

DISTRICT OF NEW JERSEY

AMINA BOOKEY MUDEY Agency A# A97-53335 Petitioner, v. ALBERTO GONZALEZ Attorney General, and, MICHAEL CHERTOFF, Secretary of the Department of Homeland Security, (DHS), and, EMILIO T. GONZALEZ Director of Citizenship and Immigration Service (CIS), and, District Director of the Citizenship and Immigration Service (CIS), Newark, New Jersey and, SCOTT WEBER Field Office Director Immigration Customs Enforcement Office Deportation Detention Newark , New Jersey and, CHARLOTTE COLLINS Warden, Elizabeth Detention Center Elizabeth New Jersey Respondents.	Civil Action No.: **DECLARATION OF LAURIE GOLDSTEIN, M.D.**

LAURIE R. GOLDSTEIN M.D., pursuant to 28 U.S.C. § 1746, declares as follows:

1. I am a licensed physician in the State of New York, and a Board Certified Obstetrician-Gynecologist ("Ob-Gyn"). I am an Assistant Attending Physician at the Mt. Sinai Hospital of New York, and a Clinical Instructor at the Mt. Sinai School of Medicine. I have had

Ann Schofield Baker, Esq.
June 4, 2008 Detainee Hearing
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experience with torture victims, like Ms. Mudey, through more than 10 years of voluntary service for Physicians for Human Rights, in their Torture and Asylum Network.

2. I submit this declaration in support of Ms. Mudey's Habeas Corpus complaint to require the government to provide immediate and adequate medical care to Ms. Mudey, an applicant for asylum from Somalia who is being detained at the Elizabeth (CAA) Detention Facility in Elizabeth, New Jersey ("Detention Center"). On the evening of August 16, 2007, I interviewed Ms. Mudey, at length, about her current medical condition. She finally had a menstrual period which ended more than two weeks ago. She has been experiencing increasingly severe lower abdominal pain, back pain, chills, vaginal discharge, and severe pain during urination, for three weeks. She has been unable to eat or sleep for days. During much of my interview, Ms. Mudey was in so much pain that she was in tears. Based on the severe symptoms that she is exhibiting, the lack of appropriate response from the medical staff at the Detention Center, and on my observation of inappropriate medical care rendered to Ms. Mudey at the Detention Center over the past several months, I believe that Ms. Mudey is in need of immediate medical attention at a hospital.

Ms. Mudey's Current Medical Problems and Lack of Appropriate Treatment

3. Ms. Mudey indicated that close to three weeks ago, she began experiencing constant abdominal and back pain. When this pain persisted for more than a few days, she brought it to the attention of her Detention Center doctor, who has not provided his name.

Communication with the medical staff in the Detention Center has been extremely difficult because Ms. Mudey speaks very little English, and needs a Somali interpreter to communicate. Although Ms. Mudey's attorneys have offered to provide a Somali speaking interpreter at no cost to the Detention Center, the Detention Center will not speak with an interpreter while rendering medical care to Ms. Mudey.

4. Ms. Mudey saw the doctor approximately two weeks ago, on or about Friday, August 3, and described her symptoms, including the intense pain she was experiencing in her lower abdomen and back. She informed the doctor of the severe pain she experienced during urination. The doctor performed no tests, conducted no physical examination, and informed Ms. Mudey that he had no idea what was causing her pain. He dismissed her without treatment.

5. When Ms. Mudey's symptoms continued to get worse, she filled out several medical request forms to have the doctor examine her. Apparently, the only way that a detainee can see a doctor, even during a medical emergency, is to fill out a request slip and place it in a designated box. The doctor did not respond, and did not examine Ms. Mudey. Instead, he sent a nurse to administer Diflucan, which is a medication to treat yeast infections.

6. Ms. Mudey's condition deteriorated rapidly, and became acute last weekend. On a daily basis, starting as early as Saturday, August 11, she filled out the medical request form and placed it in the designated box. Friends of hers in the Detention Center also filled out the form on her behalf. Ms. Mudey informed the nurse who administers her medication at night that she needed to see a doctor to address her intense pain, and she communicated the same to several guards at the Detention Facility. All of them simply told her to fill out the request slip, and put it in the box.

7. On Tuesday, August 14, 2007, Ms. Mudey was in so much pain, that she called her attorney, Ann Schofield, and asked her to intervene. Ms. Schofield immediately called the Detention Center and spoke with both a deportation officer and a member of the medical staff, neither of whom provided their names, to alert them to Ms. Mudey's need for immediate medical attention. Ms. Schofield was assured that Ms. Mudey would receive medical attention shortly.
8. Ms. Mudey continued to fill out the request slips, but no doctor came to see her.
9. On Thursday, August 16, 2007, Ms. Mudey again reached out to Ms. Schofield because Ms. Mudey had still not been seen by a doctor. Ms. Mudey was in excruciating pain, and again, was in tears on the phone.
10. Despite submitting several requests to see the doctor during the week of August 6, and despite submitting a form every single day since August 11, the doctor did not see Ms. Mudey for almost two straight weeks.
11. Only after a litany of telephone calls from various attorneys to the Detention Center, the doctor eventually saw Ms. Mudey on Thursday, August 16. However, he conducted no physical examination of any kind, and simply gave her an aspirin. He took her blood pressure, and performed a urine test which was apparently "inconclusive." However, he did not take a history of the present illness, nor did he take her temperature, perform a physical exam, palpate her abdomen, or order a urine culture. In addition, if indicated, he should have ordered a CBC (complete blood count), and a pelvic and/or renal ultrasound. Accordingly, the doctor failed to treat Ms. Mudey appropriately.
12. I believe that Ms. Mudey is probably suffering either from an acute urinary tract infection ("U.T.I."), pyelonephritis (a kidney infection) and/or pelvic inflammatory disease ("P.I.D.").

A U.T.I can be diagnosed with proper tests and can be treated with a course of antibiotics. Pyelonephritis is a serious condition that requires medical testing to confirm. It can also be treated with a longer course of antibiotics. As for P.I.D.,

It often flares up after a menstrual cycle. The only way to diagnose P.I.D. is with a gynecological exam which should be conducted immediately. P.I.D. is also a serious condition. It must be treated with antibiotics that are administered intravenously, not orally.

13. A full medical examination needs to be conducted immediately to determine the source(s) of Ms. Mudey's illness. This examination needs to be conducted with a Somali interpreter present (or via the telephone) so that the doctor and Ms. Mudey can communicate effectively with each other.

14. Ms. Mudey is suffering needlessly with intensely painful symptoms. If left untreated, these infections can cause serious complications, and in severe cases, even death.

The Detention Center's Provision of Inappropriate Medical Care to Ms. Mudey in the Past

15. This is not the first time that I have been concerned about the quality of medical care that Ms. Mudey has received at the Detention Center.

16. On June 25, 2007, under the auspices of Physicians for Human Rights, I took a full medical history of Ms. Mudey and interviewed her regarding her experiences in her home country of Somalia. I performed a full physical and gynecologic exam. In addition, I reviewed the summary of medical treatment Ms. Mudey received through the medical clinic at the Detention Center.

17. After I examined Ms. Mudey, I prepared an affidavit, dated July 6, 2007, which summarized my findings. That affidavit is attached hereto as Exhibit 2.

18. During the June 25 examination, I observed that Ms. Mudey was suffering severe side effects from an anti-psychotic drug, Risperdal, that doctors at the Detention Center had prescribed to her. As described more fully in my July 6, 2007 affidavit, I found that Ms. Mudey "appears dull, or drugged, with a shuffling gait, unblinking eyes, and a drooping lower lip. She makes continuous little tongue-thrusting movements in her mouth, and has restless legs which she cannot control. These symptoms are all consistent with extrapyramidal side effects that can occur with anti-psychotic medication." (Exhibit 2 ¶20). Moreover, the Risperdal caused on onset of galactorrhea, which caused Ms. Mudey's breasts to produce and excrete milk, even though she is not now and has never been pregnant. The Risperdal also caused amenorrhea (absence of the menstrual period). Ms. Mudey had not had a menstrual period for several months, ever since she began taking the Risperdal.

19. After my detailed clinical interview and examination, and review of Ms. Mudey's medical records, I determined that the Detention Center had no basis for prescribing Risperdal to Ms. Mudey. Risperdal is an anti-psychotic medication, but Ms. Mudey has had no signs or symptoms of psychosis. In my history taking, I found no history of psychotic behavior or seizure disorder.

20. Indeed, Dr. Katherine Falk, a skilled psychiatrist with more than 25 years experience, performed a detailed clinical evaluation of Ms. Mudey, and was equally alarmed by both the incorrect diagnosis of psychosis, and the prescription of Risperdal. Dr. Falk prepared a detailed affidavit which summarized her evaluation and her conclusions, and she talked at

length about both the mis-diagnosis and the inappropriate prescription of Risperdal. Dr. Falk's June 27, 2007 affidavit is attached hereto as Exhibit 3.

21. At the conclusion of my examination of Ms. Mudey, I wrote a letter to her Detention Center doctor in which I explained, among other things, that the Risperdal should be stopped. I also suggested several anti-anxiety medications that would be appropriate to treat her anxiety and sleeplessness.

22. I understand from Dr. Falk that she also wrote a note to the Detention Center doctor to suggest some more appropriate medications.

23. When I spoke with Ms. Mudey recently, she informed me that the Detention Center doctor was very angry with her when she provided my letter to him. She said that the Doctor told her to continue taking the Risperdal, despite the devastating side effects that it was causing her. On my advice, and on the advice of Dr. Falk, Ms. Mudey refused the Risperdal. Many of the severe side effects of Risperdal can last a lifetime if the patient does not stop taking the medication in time.

24. Ms. Mudey told me that the doctor stated, "I am your doctor, your lawyer is not your doctor" and that thereafter, he made comments to her that perhaps she should seek medical attention from her lawyer instead of from him.

25. In light of the way that the medical doctors at the Detention Center ignored Ms. Mudey's constant pleas for medical attention for almost two weeks, and the substandard care that she received yesterday, I do not believe that Ms. Mudey has received, or will receive, adequate, basic medical attention from the Detention Center medical staff. I recommend that she be taken to a local hospital immediately for a thorough examination, and that a Somali interpreter be present for this, and all future medical treatments, if needed.

I declare under penalty of perjury that the foregoing is true and correct.

Dated: August 17, 2007
New York, New York

Laurie R. Goldstein M.D., FACOG

Ann Schofield Baker, Esq.

Before the House Judiciary Committee's Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law Hearing on "Problems With Immigration Detainee Medical Care"

June 4, 2008

Exhibit 5

From: Amina Bookey Hudey Aka Sharifo Abdi
A-97-533-835

August 20, 2007

To Elizabeth Detention Center Medical Staff,

I wish to see my medical records to identify which hospital I was taken to on Friday, August 17, 2007. I am entitled to have access to my own medical records, and am entitled to know the names of each doctor who has administered medical care to me.

As you know, I do not speak English. I speak Somali. I need to have a Somali interpreter with me, or on the phone, when I speak with doctors. My attorney has offered, and continues to

(1)

Ann Schofield Baker, Esq.
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August 20, 2007
Cont'd

offer, the services of a Somali interpreter at no cost to the government. I am being denied access to proper medical care when I cannot communicate with my doctors, especially when I am willing and able to provide an interpreter for free.

You need only to call my attorney's office, [redacted], and she will connect you with a Somali interpreter. Or, if you wish to contact the interpreter directly, her name is [redacted], and her cell phone is [redacted].

This letter was written by my attorney and was read to me in Somali by my interpreter. My lawyer has obtained a copy of this letter for her records.

Amina Booker Hudey
Amina Booker Hudey
AKA Sharifo Abdi

(2)

August 20, 2007

To Detention Center Medical Staff.

I am in constant pain, and would like to be able to take Tylenol, aspirin or another pain killer, as needed during the day and at night. Other detainees are given pain medication to take, as needed. I am requesting the same courtesy.

Amina Bookey Mudey
Amina Bookey Mudey
AKA Shamsa Abdi
A97 533 835

My lawyer has retained a copy of this letter for her records.

Ms. LOFGREN. Thank you very much.
Finally, Dr. Venters?

TESTIMONY OF HOMER VENTERS, M.D., ATTENDING PHYSICIAN AND PUBLIC HEALTH FELLOW, BELLEVUE/NYU PROGRAM FOR SURVIVORS OF TORTURE

Dr. VENTERS. Thank you, and good afternoon. My name is Homer Venters, and I am an attending physician at the Bellevue/NYU Program for Survivors of Torture, as well as a public health fellow with the CDC and New York University. I would like to thank the Chairwoman and other Members of the Committee to speak here today.

Together with my colleague, Dr. Allen Keller, I have conducted an analysis of the ICE health-care system for the last 8 months. Contrary to public statements by ICE, it is our conclusion that this health system and the care it allows for detainees may be getting worse, not better.

The central thesis of my remarks is that, behind confusing and unreliable statistics concerning detainee deaths, the ICE health-care system contains key elements that may jeopardize detainee health. I will briefly review the flaws of the statistics provided by ICE, refer to several specific failures in the ICE health plan, and conclude with our specific recommendations for improving the system.

ICE reports falling detainee mortality rates, but their figures are based on unreliable calculations. The most important failure is the lack of adjustment for average length of detention. Adjusting for risk exposure, such as length of detention, is a fundamental practice of both medicine and epidemiology, and failure to do so reflects flawed methodology.

Figures for average length of detention are available for 2006 and 2007. That is why I present these years. When appropriate adjustment is applied to ICE's own mortality figures, one sees that length-adjusted mortality has increased 29 percent from 2006 to 2007.

Other misleading statistics published by ICE include hollow comparisons between deaths among detainees and among prison populations and the general U.S. population without any adjustment for age, disease prevalence or, again, length of detention.

ICE mortality figures reveal two important pieces of information. First, the length-adjusted mortality for detainees increased from 2006 to 2007. The cause of this increase is unclear, and mortality likely under-represents problems with detainee health care. Morbidity is a better marker. But it is certainly not the case the mortality has dramatically fallen during this time.

Secondly, reliance by ICE on unsound statistical methods that consistently present a more positive picture of detainee health should generate concerns about the ability of ICE to adequately access and improve its own health-care system.

This Committee has heard tragic and compelling testimony concerning the deaths of ICE detainees. I would like to mention four specific aspects of the ICE health plan that establish an unacceptable level of care for detainees and must be addressed if similar tragedies are to be averted.

First, the ICE health plan was recently changed to eliminate chronic care visits every 3 months. This change will mean that less care and less consistent care is provided to the one-third of detainees who suffer from chronic medical problems. And this is in stark contrast to the proven medical standard of establishing system-wide protocols for chronic disease management.

Another harmful practice is requiring the inclusion of nonmedical criteria in referring detainees for outside care, including whether or not failure to treat will impact deportation. This inappropriately limits cares for detainees, creates ethical jeopardy for ICE providers, and I will mention is different than the standard for the Marshals Service.

A third problem pertains to health screening. The ICE health plan, again, was very recently changed to allow basic health screening tests, such as mammograms and pap smears, and I quote, "on a case-by-case basis subject to clinical findings." Screening tests are, by definition, applied to an entire nonsymptomatic portion of a population. To wait until clinical suspicion or symptoms appear completely undermines the screening aspect of the test. It deprives detainees of the accepted medical standard of early detection and treatment, and it lets diseases such as cervical, breast and prostate cancer develop to the point of symptoms.

A final critical point regarding the ICE health plan involves the treatment authorization request, or TAR. ICE has recently scrapped the TAR appeals process but has also given off-site nurses the ability to reject TARs by detention center physicians. So now physicians in detention centers may have their treatment authorization requests rejected by off-site nurses, and they have lost the ability to effectively appeal such decisions.

We recommend the following specific changes to the ICE health plan as well as the larger infrastructure of ICE.

The ICE health plan must be altered so that health screening tests and care for chronic disease are routinely available and reflect accepted medical standards. Nonmedical criteria must be eliminated from this health plan as part of thereferral process. And detention center providers should not have TARs rejected by off-site nurses without physician review and without possible appeal.

Other changes to the larger ICE health system should include mandatory reporting of vital health statistics, including morbidity, not just mortality, to a body outside Homeland Security and routine consideration of parole for seriously ill detainees.

Finally, the health-care system for ICE detainees must be guaranteed and defined as a matter of law. Many of the deaths reported among ICE detainees involve poor adherence to existing ICE guidelines.

Unfortunately, the present response of ICE to the overwhelming evidence of inhumane health care for detainees shows that officials are more concerned with public relations than confronting a grim medical reality suffered daily by immigrants in detention.

I thank you, and I'd be happy to take any questions.

[The prepared statement of Dr. Venters follows:]

PREPARED STATEMENT OF HOMER D. VENTERS, M.D.

Good Afternoon. My name is Dr. Homer Venters. I am an attending physician at the Bellevue/NYU Program for Survivors of Torture as well as a Public Health Fellow with New York University. I am testifying today on behalf of the Bellevue/NYU Program for Survivors of Torture and the NYU School of Medicine Center for Health and Human Rights. I would like to thank Congresswoman Lofgren and members of the Subcommittee for inviting me to testify on immigrant detainee healthcare. My area of research as a Public Health Fellow is the medical care provided to Immigration and Customs Enforcement (ICE) detainees. Together with my colleague, Dr. Allen Keller (Director of the Torture Survivors Program and the Center for Health and Human Rights) I have conducted analysis of the ICE healthcare system, including the mortality statistics recently released by ICE and the specific provisions of the ICE health plan. My comments today focus on these two areas and I will provide recommendations for improvements of the ICE healthcare system. The central thesis of my remarks is that behind confusing and unreliable statistics concerning detainee deaths, the ICE healthcare system contains key elements that may jeopardize detainee health. Contrary to public statements by ICE, it is our conclusion that this health system, and the care it allows for detainees, is getting worse not better.

I. Misleading Mortality Statistics

I would like to begin with the recent discussion of detainee mortality reported by ICE. I am referring to the ICE fact sheet on detainee deaths dated May 2008 [1] as well as the Op-Ed by Assistant Secretary Myers in the Washington Post.[2] In these documents, ICE relies on inappropriate use of basic epidemiologic terms and inaccurate comparisons between populations known to be radically different. The lack of standardized mortality or morbidity reported in these documents provokes grave concern for the welfare of ICE detainees and the ability of ICE to monitor the quality of its own health care system.

ICE reports falling detainee 'mortality' rates but their figures are based on unreliable calculations. In Fiscal Year 2006 ICE detained approximately 250,000 people while in 2007, that number rose to 310,000. Because the total number of detainee deaths dropped from 17 to 11 during those periods, ICE claims that the mortality rate fell from 6.7 to 3.5 per 100,000 detentions, a 49% decrease.[3] However this conclusion neglects a very basic and essential issue, the length of detention. From 2006 to 2007, the average length of ICE detention decreased from 90 days to 37. Adjusting for risk of exposure (such as length of detention) is a fundamental practice of both medicine and epidemiology and failure to do so reflects flawed methodology. For instance, no physician would make conclusions about a patient's risk from smoking without including how long that patient had been a smoker. Taking ICE's same fiscal year numbers, but correctly adjusting for average length of detention, it is clear that the length-adjusted mortality actually increased between 2006 and 2007 from 27 to 34 per 100,000 detention-years, a 29% increase (see Table 1 for side by side comparison).[4] Consequently, the statistics presented by ICE tend to present an unduly rosy picture of detainee mortality.

A second glaring weakness in the ICE statistics is found in their comparison between deaths of ICE detainees and those in a general prison population. Again, the lack of standardization for length of detention makes this a flawed comparison, since prisoners are typically held for a longer period of time in a given year than are ICE detainees. For example, imagine that ICE detained 300,000 people per year for one day each and U.S. prisons detained 300,000 people each for a full year. It would be incorrect to conclude that because fewer people died in ICE custody than in prison custody, the healthcare provided to ICE detainees was somehow superior. The fact that the average ICE detainee spends so much less time in custody than the average prisoner in a given year must be factored in to provide any meaningful results.

Aside from lacking standardization over a given year, any comparison of ICE detainees to prisoner populations is dubious because prisoners are incarcerated for much longer periods of time in total than ICE detainees. Prison research has shown that mortality rates increase with time of incarceration, so even if ICE had standardized for time detained in a given year, prisoners who have accumulated years of prior detention are known to have higher rates of mortality.[5] Also, when ICE favorably compares mortality of detainees to those of prisoners and the general population, there is no adjustment for age or disease prevalence. For example, U.S. prisoners have high rates of infectious disease, and the general U.S. population may be older, suffering from higher rates of heart disease and cancer than the ICE population. Without correct adjustment for these types of possible differences, the figures provided by ICE are unreliable.

To be clear, mortality is an imprecise method for appraising healthcare in a transitional population. Because death is rare and detention is short, mortality likely under-represents problems with health care delivery among ICE detainees. Morbidity, which refers to sickness or having a disease, is a better measure of the efficacy of ICE healthcare since by ICE estimates, at least 34% of detainees suffer from chronic diseases.[6] Consequently, complications from poorly controlled chronic disease, such as diabetes, HIV, asthma or hypertension are more sensitive health care measures. Unfortunately, ICE makes reports no specific information about morbidity of detainees. However, even morbidity may under-represent adverse effects of this system. As with mortality, shorter detentions will tend to produce fewer adverse events. In thinking of ICE detention as a risk factor, as ICE detention time shortens, the likelihood is that adverse events caused by this risk will occur afterwards. This may have been the case with Juan Guillermo Guerrero, 37, who was denied his seizure medicines while detained by ICE and died of complications from seizures shortly after being deported to Mexico.[7]

This discussion of ICE detainee mortality reveals two important pieces of information. First, the length-adjusted mortality for detainees has increased from 2006 to 2007. The causes or significance of this increase are unclear but it certainly is not the case that detainee mortality is dramatically falling, as ICE has asserted. Second, the reliance by ICE on unsound statistical methods that consistently present a more positive picture of detainee health should generate concerns about the ability of ICE to adequately assess and improve its own healthcare system. Our review of the ICE health plan, including recent changes, suggests that ICE detainees are receiving medical care that is increasingly limited and inconsistent with current standards of medical practice.

II. An Acute Care Health System for a Population in Need of Much More

The healthcare provided for ICE detainees is directed by a set of rules under the Detention Management Control Program of the Department of Homeland Security (DHS). This program creates procedures for ICE detention operations but does not carry the force of law. Particular medical policies and reimbursement guidelines are determined by the Division of Immigration Health Services (DIHS), recently incorporated into DHS from the Health Resources and Services Administration of the U.S. Department of Health and Human Services. DIHS guidelines then become part of the overall set of ICE rules for detention operations.[8] Despite acknowledging the substantial burden of chronic disease among detainees, the ICE health plan maintains a steadfast focus on an acute care model. The 1/3 of detainees with medical problems that require ongoing, skilled care for problems such as diabetes, hypertension, asthma and HIV find themselves in a medical setting geared towards addressing ankle sprains, cuts and bruises and calling 911 in case of emergency. Unfortunately, the ICE health plan is clearly not crafted to care for a population with significant chronic medical or mental health needs. The introduction of the ICE plan explains "The DIHS Medical Dental Detainee Covered Services Package primarily provides health care services for emergency care. Emergency care is defined as 'a condition that is threatening to life, limb, hearing or sight." [9]

This institutional aversion to caring for detainees with chronic disease is evidenced in recent detainee deaths. One year ago, a 23 year old transgender woman, Victoria Arellano was detained by ICE.[10] Ms. Arellano had AIDS and was taking a life saving medicine to prevent opportunistic infections that could quickly cause pneumonia and death were she to stop. These medicines are essential for people with AIDS and even a brief interruption risks sickness and death for a patient. Despite reporting her medical history and her medication when detained (and throughout her detention), Ms. Arellano was refused her medicine. Over the following weeks, Ms. Arellano developed a cough and fever, which should have prompted hospitalization and evaluation. Instead, Ms. Arellano was given an inappropriate antibiotic by the detention center medical staff, was still refused her needed medication, and returned to her cell. By the time Ms. Arellano's cellmates staged a protest to draw attention to her deteriorating condition, she had become very ill and died soon thereafter, comatose and shackled to her bed. Faced with a common chronic disease, ICE medical staff withheld the correct medicines, gave inappropriate medicines and failed to seek more competent care for Ms. Arellano. The care that Ms. Arellano required would be routine in almost any medical clinic or hospital in the United States.

Among the most prevalent chronic diseases from which detainees suffer may be depression and anxiety. The prevalence of these conditions is difficult to gauge in part because detainee may fear being placed in segregation should they report mental health symptoms. This fear was documented in study conducted jointly by the

Bellevue/NYU Program for Survivors of Torture and Physicians for Human Rights in 2003 among asylum seekers (admittedly, a small subset of all detainees). This report found that "the mental health of asylum seekers interviewed for this study was extremely poor and worsened the longer that individuals were in detention." In this study, symptoms of depression were present in 86% of the 70 detained asylum seekers, and anxiety was present in 77% and PTSD in 50%.[11] The study also documented significant difficulties for immigrant detainees accessing health services for painful and sometimes dangerous health problems. Unfortunately, recent reports by the Washington Post and New York Times demonstrate that the problems with detainee healthcare documented in 2003 are not new and have not been corrected. In fact the concerns are even greater today, given that current immigration policies continue to dramatically expand immigration detention.

The fear of arbitrary and inhumane segregation is not hypothetical and has real bearing on the health of ICE detainees. In 2007, a 52 year old man from Guinea, Boubacar Bah, fell while in ICE custody and sustained a head injury.[12] Mr. Bah was transferred to the medical unit of the detention center but when he became agitated, confused and vomited, Mr. Bah was written up for disobeying orders and transferred to segregation (a euphemistic term for solitary confinement) with approval of medical staff. The behavior that served as an excuse for disciplinary transfer to solitary confinement was in reality a sentinel sign of intracranial bleeding. The most shocking aspect of this case is that Mr. Bah was actually in the medical unit, under the care of ICE medical staff when the ill-conceived idea to place him in solitary confinement was approved. Mr. Bah's condition deteriorated steadily under the watch of ICE personnel until 14 hours after his fall, foaming at the mouth and unresponsive, he was transferred to a hospital. Mr. Bah was quickly diagnosed with a fractured skull, multiple spots of bleeding in his brain and ICE notified his family five days later of his condition. Mr. Bah died several months later without ever regaining consciousness and ICE medical staff originally reported his cause of death as 'aneurysm' without any mention of his fractured skull. While most detainees who are inappropriately placed in solitary confinement do not die, this case illustrates how very basic medical judgment can be abandoned in the detention setting. A man who had just fallen and lost consciousness, already inside the medical unit, was somehow judged to be 'disobeying orders' instead of manifesting a clearly recognizable sign of head trauma. Solitary confinement is obviously inappropriate for someone who is ill, but this case and others call into question the very practice of placing detainees in such a setting.

III. Specific Weakness in the ICE Health Plan Imperil Detainees

In addition to the broad institutional problems facing detainees who require medical care, there are very specific aspects of the ICE health plan that warrant concern. DIHS has altered the Covered Services Package several times in the past few years, limiting the scope of medical care for detainees. Publicly reported deaths of detainees have included cases in which persons with chronic diseases were refused access to care outside their respective detention centers.[13] The refusal for this care comes in the form of a Treatment Authorization Request (TAR) submitted by local medical staff at a detention center and denied by DIHS. Before 2005, the Covered Services Package entitled detained with chronic medical problems to 'chronic care' visits every three months. In 2005, the Covered Services Package was changed in the following manner: "we have clarified to providers that DIHS does not mandate the frequency a detainee is seen or what testing needs to be done by the onsite physician. The responsibility will lie with the provider." [14] In stark contrast to these recent changes by ICE, there is clear and convincing evidence that establishing system-wide protocols for chronic disease diagnosis and treatment (including pre-approved visits, tests and treatments) results in decreased mortality and morbidity.[15,16,17] Because this change eliminated any notion of standard of care (such as a set protocol for treating specific diseases), and further increased the burden of securing prior approval for outside care, the net effect may have been to limit care for detainees with chronic medical problems. One tragic example is Francisco Castaneda, a 34 year old man from El Salvador, who was detained for 11 months by ICE with bleeding penile lesions. Despite numerous physicians documenting concern that his lesions were cancerous, DIHS refused the TAR for biopsy labeling the test 'elective'. After being released from detention, Mr. Castaneda was finally able to receive appropriate evaluation and treatment. But by then it was too late and Mr. Castaneda died shortly after beginning treatment for metastatic penile cancer.[18]

Another potential threat to detainee medical care is the requirement of the Covered Services Package that mandates that detention center medical providers include non-medical criteria in any potential referral for outside care. The Covered

Services Package allows non-emergent care with the following explanation: "Other medical conditions which the physician believes, if left untreated during the period of ICE/BP custody, would cause deterioration of the detainee's health or uncontrolled suffering affecting his/her deportation status will be assessed and evaluated for care." [19] With these conditions, ICE simultaneously demands that a care provider estimate the length of detention for a detainee and assess whether or not deterioration of the condition might impact deportation. Both of these non-medical criteria potentially limit the care provided to detainees and likely create ethical (and potentially legal) jeopardy for ICE providers. In contrast, the U.S. Marshals Service relies on medical necessity alone in establishing criteria for outside referral.[20]

A third problem with the care allowed under the Covered Services Package pertains to health screening. Originally (prior to the 2005 changes), the plan approved basic health screening tests such as mammograms and pap smears only after one year in detention. This guideline was substandard because many detainees likely had little or no prior health screening and would have benefited from indicated health screening tests (as is the standard at Rikers Island Jail in New York City, where average length of stay is shorter than average ICE detention).[21] But even this substandard coverage was further reduced in 2005 when the Covered Services Package substituted diagnostic criteria for what they continued to call screening tests. The new guidelines stated: "screening for disease processes (e.g., breast, cervical, prostatic, colorectal cancer) are considered on a case by case basis, subject to clinical findings . . . In other words, clinical findings must support the need for the requested screening. This change will remove the impression that these tests are automatically approved for a detainee who is in custody for over 12 months." [22] Screening tests are by definition, applied to the entire non-symptomatic portion of a population. For example, in discussing Pap smears, the U.S. Preventative Services Task Force recommends screening for cervical cancer in women who have been sexually active and have a cervix.[23] There is no reference to symptoms or clinical suspicion in this, or any other screening recommendation and to wait until clinical suspicion or symptoms appear completely undermines the 'screening' aspect of the test. This difference is enormously important because while ICE continues to call these tests 'screening', they are in fact forcing tens of thousands of people to forgo some of the most beneficial and cost-effective measures of modern medicine. By waiting until detainees show symptoms or arouse clinical suspicion of a disease, ICE deprives detainees of the accepted medical practice of early detection and treatment in favor of letting diseases such as cervical, breast and prostate cancer develop to the point of symptoms.

A final but critical problem with the ICE health plan involves changes in how each Treatment Authorization Request (TAR) is processed. Prior to changes in 2005, detention center medical staff could submit a TAR and if it was rejected by DIHS, they could appeal this refusal. These appeals were reviewed by a team of 3 DIHS physicians. This formal appeal process was scrapped in 2005 in favor of a 'grievance' process that eliminated the physician review component. In addition, in 2007 ICE changed the guidelines for refusing TAR's so that DIHS nurses could reject a TAR without any input from the DIHS medical director. Such oversight by the medical director was required for rejection of TAR's prior to this change. The net effect of these two changes is that physicians in detention centers may have their TAR's rejected by off-site nurses and they have lost the ability to appeal such decisions to a group of physicians.

IV. Recommendations

We recommend several specific changes to the DIHS Medical Dental Detainee Covered Services Package as well as to the larger health infrastructure if ICE. Without these changes, we are concerned that all detainees held by ICE face an unacceptably low standard of medical care that will adversely affect their health.

1. The DIHS Medical Dental Detainee Covered Services Package must be altered in the following ways:
   A. Care for chronic disease must be routinely available and reflect community standards for the care of HIV, diabetes, hypertension and other common chronic diseases. Part of these improvements must include pre-approval for standard, foreseeable care.
   B. Health screening tests must be made available based on prevailing medical standards and any mention of 'clinical suspicion' or 'symptoms' must be eliminated from criteria for these tests.
   C. Non-medical criteria must be eliminated from the process of detention center medical staff seeking a TAR for detainees. Specifically, the mandate that

ICE providers balance a deteriorating condition and uncontrolled suffering against the ability to deport the detainee or estimate a detainee's length of detention must be eliminated from the health plan.

D. TARs generated by physicians should not be rejected by nurses without review by a physician. Any TAR rejected by DIHS should be open to a genuine appeal, including review by physicians

2. ICE should be mandated to report vital health statistics (including deaths, disease complications, accidents and forcible medical actions against detainees) to a body outside DHS with expertise in public health and epidemiology. One possible solution would be to return DIHS to the Health Resources and Services Administration of the Department of Health and Human Services and include an ICE medical monitoring division.
3. Detainees with serious medical ailments requiring high levels of care should be routinely considered for parole. The correctional setting is an inefficient and inhumane venue for persons with medical problems requiring high levels of ongoing medical care.
4. Healthcare for ICE detainees must be guaranteed and defined as a matter of law. Many of the deaths reported among ICE detainees involve poor adherence to existing ICE guidelines. Greater accountability is needed to ensure compliance in healthcare standards across the wide spectrum of detention centers.

These improvements will require substantial effort, including financial investment. Currently, ICE argues that the number of medical visits, procedures and overall medical budget ($100 million) demonstrate a high degree of care for detainees. But these details tell us nothing about key factors in care delivery, including delays in treatment and the nature of visits. Several detainee deaths involved delays in care and the explosive increase in immigration detainees has outpaced increases in medical spending. Moreover, $100 million may be a low health care budget for a system that detains 300,000 people per year. By comparison, Rikers Island Jail in New York City detains roughly half the people annually and on any given day that ICE detains, but has spent over $100 million annually on healthcare for over a decade for a population that is generally detained for less time than ICE detainees. Without transparency from ICE on basic health outcomes or costs, ICE's raw expenditures tell us little about the efficacy of this system of care.

We believe that the most basic principles of decency and sound medical practice demand that an adequate standard of health care for detainees be legally mandated aggressively enforced and that basic health outcomes among detainees be reported for evaluation outside ICE. Unfortunately, the present response of ICE to the overwhelming evidence of inhumane healthcare for detainees shows that officials are more concerned with public relations than confronting the grim medical reality suffered daily by immigrants in detention.

Table 1.

Year (fiscal)	**Number of Annual Detentions** (by fiscal year)	**Average Detention** (days)	**Detention-years***	**Deaths** (fiscal year)	**Crude Mortality**** (deaths/100,000 detentions)	**Length-adjusted Mortality** (deaths/ 100,000 detention-years)
2006	254,383	90	62725	17	6.9	27.1
2007	311,213	37	31548	11	**3.5(49% decrease)**	**34.9(29% increase)**

* From number of detentions multiplied by average detention length, divided by 365

**Mortality figures reported by ICE

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Ms. LOFGREN. Thank you, Dr. Venters and all of the witnesses.

This is a time when we have an opportunity to ask a few questions. I have several.

First, Ms. Armendariz, your testimony is so hard to listen to due what occurred. He had been treated at the VA for years, because he was a veteran, and they had diagnosed him with schizophrenia.

Ms. ARMENDARIZ. Fifteen years.

Ms. LOFGREN. Okay. So that is a Federal facility with Federal medical records. Were those records ever made available to ICE?

Ms. ARMENDARIZ. I guess it didn't mean anything to them at that time. I told them—or his attorney told them.

Ms. LOFGREN. Okay. So that answers one question, that the medical records we were told this morning that always follow, there is a problem there, it appears.

Ms. ARMENDARIZ. The first facility, because he was in San Antonio, the first facility, he fell down. And his face, I thought they had beaten him, and it was because they gave him strong Thorazine. It had side effects. And that is when I got advocacy involved.

Ms. LOFGREN. Right.

Ms. Asfaw, you have been granted political asylum here in the United States. You received very abusive treatment in your home country. When you were put into custody after you made your indication to apply for asylum known, was there any effort to provide information or care to you to deal with the things that had been done to you that you had escaped?

Ms. ASFAW. Yes.

Ms. LOFGREN. And what were those things?

Ms. ASFAW. Back in my country?

Ms. LOFGREN. No, here in the ICE facility, did anybody in the ICE facility try to help you cope with the things that had been done to you in Ethiopia?

Ms. ASFAW. Yes.

Ms. LOFGREN. And what were those things?

Ms. ASFAW. I don't understand.

Ms. LOFGREN. Okay. That is all right. I will follow up in writing with you on that. That will be easier.

Let me ask you, Ms. Baker, your testimony is very compelling. First, 600 hours is a lot of billable hours. I think it is pretty admirable that you have donated and your firm has donated that kind of time on a pro bono basis.

You, I think, were here this morning to hear the testimony of Ms. Myers. How does her testimony compare to what you saw as an attorney with a client last year?

Ms. BAKER. You mean as opposed to the Rolls Royce of medical treatment?

Ms. LOFGREN. Correct.

Ms. BAKER. There are very clear systemic problems, as evidenced by my client's case and by a number of other people's cases who have testified here today.

Number one, there are no interpreters. In the 5 months that Amina was in ICE detention, she didn't once have a medical examination or treatment with an interpreter.

Ms. LOFGREN. Did you offer to provide that for her?

Ms. BAKER. I offered to provide—as soon as I came into the case, I realized that there were glaring miscommunications, and I offered to provide them with an interpreter for months in writing, and no one ever called. They refused to do it.

I still to this day, as I have said, have not seen her medical records. I think the medical care that she was provided, I mean, even if you can look the other way at a misdiagnosis in the first place and say they thought maybe she was psychotic but really wasn't, when you have the side effects that she was exhibiting, it's just inexplicable that none of the medical professionals got it.

A gynecologist who I brought in instantly figured out that she was on an antipsychotic drug. And the psychiatrist figured out it was Risperdal, because at the time we didn't have her medical records, when Dr. Kathy Falk examined her. So the side effects were just catastrophic, and they completely either missed them or, worse, knew about them and increased the dosage anyway.

Ms. LOFGREN. Well, you provided them with a second opinion with outside physicians, right?

Ms. BAKER. Two second opinions. They actually wrote full letters to them. I didn't get to this in my testimony, but later on—and I started writing letters, too, saying, "I'm Amina Mudey. I don't speak English. And I demand my medical records. My lawyer is writing this on my behalf." The inside doctor eventually gave all of the letters back, including at least one letter written by the doctor, told Amina, "Tell your lawyer to stop writing me letters."

Ms. LOFGREN. Ms. McCarthy, before my time runs out, your agency is in a lot of facilities doing pro bono assistance. You heard the testimony this morning from Ms. Myers. Does that, sort of, rosy picture that was given to us comport with what you are seeing in the facilities?

Ms. MCCARTHY. Unfortunately, no. I think what is really alarming is the lack of attorneys available to represent detainees, the number of which is increasing dramatically.

The three stories that we have heard today are stories of people who had legal representation and advocates. Just imagine what it is like for those individuals who do not have legal advocates. Unfortunately, Ms. Belbachir was one of those individuals. She was a suicidal asylum seeker who had no one from outside the ICE facility to advocate for her.

There is no court-appointed counsel available for immigrants who are detained or placed in legal proceedings. Individuals are detained and deprived of their liberty and their only option for medical help, as the system is set up right now, is through Immigration and Customs Enforcement.

Ms. LOFGREN. Thank you very much.

My time has expired, so I'll turn to the Ranking Member, Mr. King, for his questions.

Mr. KING. Thank you, Madam Chair.

In listening to the testimony, I want to say that I surely don't doubt the testimony that's before us here, and I don't doubt that there are tragic human circumstances that take place. There are 300 million people in America and 6 billion people on the planet, and there are going to be many, many of these stories. And it is a small sampling that you have delivered here today.

One of our jobs is to evaluate the policy that exists against the policy that's proposed and see where the data that's delivered to us matches up to that and also see where the anecdotes that are delivered to us matches up to that.

And with that in mind, I'd turn first to Ms. Baker and ask you: What in Ms. Lofgren's bill, that is really part of the subject here today, even though it's not formally the bill that's before us in the hearing, what in that bill would have alleviated the circumstances that you testified with regard to today regarding your client, Ms. Mudey?

Ms. BAKER. The bill, as I understand it—and I have to admit that I only read it once about 2 weeks ago, so I'm not fully prepared to discuss the terms of it today—but that it creates a standard for the care that's provided. It's effectively like a bill of rights, as I understand it, that these kinds of situations just simply can't be swept under the carpet, that there needs to be some kind of standard set for the care provided to these people.

Mr. KING. And so, to summarize that answer, and I understand it this way too, that it provides a cause of action and perhaps a means of appeal. But it probably would have not have intervened before these circumstances took place. That's a point that I think we need to keep in mind here. And I appreciate the balance of your answer.

And I'd turn to Bishop Riley. I'm, of course, very interested in your testimony and very respectful of you as a man of the cloth and the tone that you bring here as well.

And I have a question that drifts in my mind with regard to, let's just say, human dignity. Human dignity is, in my judgment, a basic human right that should be provided to every human being regardless of their citizenship or whether they are lawfully present or whether they are not.

Do you draw a distinction between human dignity and human rights in any way that you'd like to describe to this panel?

Reverend RILEY. I think that human dignity is a human right. It's one of the rights.

Dignity—let me give you an example of a lack of dignity. One of the things that often happens is that when our detention facilities like the one in Elizabeth fills up, then folks are farmed out to the county jail. If you are farmed out to the county jail, such as Monmouth County, no matter what you're there for, if you're an asylum seeker or whatever, then you wind up being stripped searched for drugs with the rest of the criminal population.

Mr. KING. Reverend Bishop, wouldn't that also be true for someone who was, let's just say, someone who was lawfully or unlawfully present in the United States? Because that is the next piece of this question.

Let me make it—there's four parts. I think there is a distinction between human dignity, which should be provided to all people, but then between that and human rights and between human rights and the distinction between those lawfully present and those unlawfully present in the United States, as well as the distinction between the rights of U.S. citizens.

Those four definitions, do they have a distinction in your mind? And do you draw those distinctions, as far as supporting the laws of this Nation with regard to immigration?

Reverend RILEY. As you pointed out when you started this question, I come at this from a little bit different perspective, in that I look at all of the people as part of the family of God and the children of God. And so everyone in that vision is equal.

I believe that the country has to have and maintain its laws, no question about that. And I think those laws need to be applied equally across the board.

But I think it's also true that at the heart of our law is respect for human beings, wherever they come from, whoever they are.

And I think that's at the crux of this matter, is that our own failed laws, frankly——

Mr. KING. Well, and I appreciate your point.

Reverend RILEY [continuing]. Put us in this situation.

Mr. KING. And so I'm asking you, do you believe that it's possible for ICE to enforce current immigration law and still provide for human dignity and still provide for the human rights that you and I believe in?

Reverend RILEY. If ICE is an extension of this Government that is me, because this Government is by the people, then I expect ICE to do this.

I don't believe ICE is conforming to its own policies. I think that's why we are here today, is that law is going to have to be enacted to get ICE to respond to its own written policies in terms of its standards of care.

Mr. KING. But you do believe it is possible to enforce the law and still provide for human dignity and human rights under the current law?

Reverend RILEY. I would hope that it is.

Mr. KING. I would, too, Reverend. Thank you for your testimony.

And thank you all for your testimony.

I yield back the balance of my time.

Ms. LOFGREN. The gentleman's time has expired.

I turn now to the Chairman of the Judiciary Committee, Chairman Conyers.

Mr. CONYERS. Thank you very much.

I commend the witnesses.

Steve King and I have agreed to send a letter to the lady that was the head——

Ms. LOFGREN. Ms. Myers.

Mr. CONYERS. Yes, Ms. Myers, with the testimony of Ms. Armendariz and ask her to respond to it so we can find out where she comes down on it.

This is one of the times I would've liked to have had this panel go first and see how that might have affected her testimony or what comments she would've had about this at all. But anyway, I think this has to be continued.

You know, this doesn't sound like this is in America this kind of thing is happening, to me. I mean, if you told me—I could name a number of countries that if you said this, I'd say it's awful and it's too bad they do things like that over there. But this is happening right under our nose.

And I am beyond shock now, having been in this body enough years. But this is stunning testimony that needs to be followed up on.

Now, could I ask anybody that knows what type of physician or physicians are on staff at the ICE facilities?

Yes, sir?

Dr. VENTERS. I have interacted with some of the medical staff when I do my evaluations. And so, generally, they're internists. I think Elizabeth Detention Center right now has a cardiologist who was trained as an internist and then has specialist care in cardiology. But, generally, internists or family practitioners, if they are

physicians. However, a great many of the smaller facilities may have a physician's assistant or a nurse.

I think the goal is to have a physician there during business hours, for a lot of these facilities, and then they have someone else to cover the evening and weekends.

Mr. CONYERS. Well, I guess the first thing the Committee might want to do is find out what kind of medical practitioners or health providers are at each facility. That would help us get off the ground.

And dare I ask, are there any psychiatrists or psychologists at any of these facilities that we know of?

Ms. BAKER. I cannot state with certainty that my client was seen by a psychiatrist. However, in reviewing her medical records, it said something like "seen by psych." But the person's name was never identified, as far as I can tell, so I'm not sure who prescribed the Risperdal to my client. There may have been a psychiatrist, but I can't say for sure.

Mr. CONYERS. Well, what else are we to make, Attorney Baker, of the way you were treated? I mean, for goodness sake, how many people, if they had counsel, would have people of your professional caliber making regular, logical interventions with questions and so forth? And they were shrugging you off like, please get out of my way.

Ms. BAKER. They were sick of me, I will tell you that much. They definitely were sick of me.

But the thing that bothers me most in all of this—well, there are many, but one of the things that bothers me the most is the audacity of the person on the other end of the phone when I called and said, "I'm about to call 911 because you have someone who is doubled over in pain, who has not been seen by a doctor for 2 weeks," and I had a doctor on the phone who prepared an affidavit who identified that this was a life-threatening, potentially anyway, a life-threatening situation, as much as she could tell over the phone. And then 2 days went by before anybody went to see her. And they went to see her only after my colleague, Adam Pearl, and I got back to the phone and started saying, "Hey, you told me someone was going to go and see what was wrong with my client," and nobody ever did.

Mr. CONYERS. Well, one last intervention here. Ms. McCarthy, Attorney Baker, how do we deal with this lack of legal representation problem? This isn't going to be cured by pro bono. There are not enough lawyers and law firms in America that they can produce the Bakers around here to provide—we are in a hell of a situation.

What do you tell the Congress to do?

Ms. MCCARTHY. Well, I think there are a number of issues, but I think the most significant issue, as I said in my comments, is the overuse of the immigration detention system. Is it necessary to have all of these individuals locked up at taxpayer expense? This is administrative detention; this is not criminal detention.

I question whether it's necessary that we lock up men and women who are, many times, hardworking members of our community, need access to medical careoutside of the immigration detention system, or are asylum seekers merely seeking protection.

Mr. CONYERS. Do you have some studies or proposals or essays that suggest that the answer is, no, that we shouldn't be locking up so many?

Ms. MCCARTHY. The Vera Institute of Justice has conducted a study in which it followed individuals who were released from detention to determine what the outcome of their immigration proceedings was. The study demonstrated successful results, because upon release from detention the immigrants were paired up with attorneys, they had access to health care, they had access to social services, and they had access to religious communities that supported them. So I think it's a very, very viable model.

Mr. CONYERS. Well, maybe King and I can work on analyzing this. The window of opportunity is closing here in the 110th Congress, but maybe we can work on getting some more information about what's going on and whether it is necessary or is this overkill.

I mean, this sounds like we're in a country other than America about what's going on here.

Ms. BAKER. I would definitely support the notion of having more of these asylum seekers paroled, certainly.

My client actually investigated trying to get parole, but this is an interesting fact, is that the document that her deportation officer or one of the deportation officers gave me to fill out included a very onerous financial statement and obligation on the part of the parolee that said they would——

Mr. CONYERS. That it would cost them?

Ms. BAKER. Yes. It was something to the effect that if you were going to sponsor someone for parole, you had to sign a document that said, I'm going to support this person for 10 years.

And I'm told—remember, I'm the newbie on the panel. This is my first asylum case. And if I get something wrong, I'm sure my colleague will correct me.

But it's my understanding that the form I was given by the ICE official was created for a completely different purpose other than parole of an asylee.

So she had someone who was willing to house her in the interim, but I couldn't get her out because that person didn't make enough money.

Ms. MCCARTHY. I might just add to this discussion because I know Ms. Myers spoke today about the asylum parole process, but I think there are some serious flaws in that parole process. It needs to be reviewed and monitored. When ICE issues a decision to deny parole, that decision should automatically and immediately be reviewed by a Federal court judge. That review does not exist today.

Mr. CONYERS. Thank you very much.

Ms. LOFGREN. Thank you, Mr. Chairman.

I'll turn now to my colleague, Mr. Gutierrez.

Mr. GUTIERREZ. Well, thank you very much, Madam Chairwoman, for putting together this hearing. I think the testimony has been very eloquent and very clear.

I'd like to say hello to Ms. McCarthy from Chicago, say a special hello to her, and like to thank the witnesses who have come forward, Ms. Armendariz, for their personal testimony in this case.

Look, you were here, the witnesses were here, and I think the members of the panel were here. We heard the representatives of the Federal Government. I've been in Congress now for 16 years. I've had many witnesses, few of them as belligerent, as questioning of our authority as we've had here this morning.

I would share with my colleagues on this panel that that has been my experience with ICE. In the Chicago area, when the head of ICE was asked, "Did you actually pick up every Latino male between 18 and 35 regardless of any other information?", she said yes, and she said she did it proudly, that that was her mission, enforcement. I mean, this is the police in the strictest sense of the word, and I won't go any further in terms of defining them.

ICE works with our Justice Department. You think that they only hold the parolees? Then they call the Justice Department, and the Justice Department fights in the court to deport those parolees after they've asked for asylum.

So I think we have a great problem here. The eloquence of the witnesses who have suffered so much here today at the hands of ICE and our justice system are but the tip of the iceberg. We receive cases like this almost every week that come into our office, people pleading.

It is very difficult to believe that we can trust an agency—and I think there was a question asked earlier about the AMA and having an outside agency come in and intervene and use standards outside. It is very difficult to watch the Federal Government watch the Federal Government when the Federal Government's mandate almost is to deport as many people as quickly as possible regardless of the consequences.

How do we take the testimony seriously about health care when—we are going to ask, Mr. Chairman—I think you and Mr. King should write that letter. We wrote a letter asking about ICE sitting across the country, outside of child care centers. That is where they put ICE agents. And we got a letter back from them basically telling us, "Send us some more information." If there had been a little more time, I would have asked her: Did you actually ask the ICE agent if they are sitting outside?

I mean, one of the purposes should be to make us safer, to make us more secure. I don't know that having ICE agents sitting outside of daycare centers makes us—I'll tell you who it doesn't make more secure. It doesn't make the moms and the dads that have to take their children to those daycare centers feel more secure. What they do, Mr. Chairman and Madam Chairwoman, is they take those children to work with them.

I mean, we had this wonderful raid, and we should really, really have a hearing on this raid in Iowa because there were serious allegations of sexual abuse on the part of the managers and owners of the facility, not paying them wages, serious child labor infractions. And while one hand of the Federal Government, the Department of Labor, is investigating very serious allegations against the owners and the managers of a meat plant, guess what happens? ICE comes in, arrests everybody, deports over 145 people, and all of the witnesses are gone.

I mean, you can exploit this labor as readily as possible as long as you have an ICE institution that will come in and cause a raid.

I mean, 98 percent of the prosecutions that ICE conducted were against individuals, not against the owners of the factories, last year, but against the individual people.

And let me just end with this. I would like to just join Bishop Riley in this sense. Not all of us think all human beings should be treated differently because they are American citizens or because of their legal status in this country. I have heard many of my colleagues speak eloquently about their great faith and their great faith in the Christian faith. And I'm not a theologian, but, you know, I went to Catholic school for a few years. I remember two fundamental lessons: to love God above everything else and to love my neighbor as I love myself.

Now, when I go to church on Sunday, the undocumented sit in the pews. They receive the body and the blood of Christ with me as we go up, and we don't ask them. And if I really love my neighbor as I love myself, if I am an American citizen and I have guarantees of this country as an American citizen, and I love my neighbor as I love myself, then I want them to have better and greater guarantees than the ones that I have.

And I think that that is really the mission of this panel and the Congress of the United States, to make sure we treat everyone as well as we expect to be treated, that is here in this country.

And I thank the gentlelady, Chairwoman for the extension of the time.

Ms. LOFGREN. Thank you.

I yield now to Mr. Ellison.

Mr. ELLISON. Let me join with my colleagues in thanking all of the very compelling, very informative testimony.

And I also just want to add a very favorable support for the level of passion that the advocates possess. We need you to help our country run better, and I thank you for what you've done and what you've said today.

You know, I practiced criminal law for 16 years. I never was an immigration lawyer, so I don't really know the process. I know that when I appear with a client, the prosecutor would argue that they were a flight risk or that they were a danger to public safety, and I would usually argue that they weren't, and the judge would make a decision.

What are the criteria you use when a person who is in detention, when the question of their release is before the court? What's it like?

Just I think it is good for the record and for people watching to know what kind of analysis the magistrate is going to apply in deciding to let a person be on parole or have a person stay in custody.

Ms. MCCARTHY. This a very important point. The fundamental difference between criminal detention and the detention system of immigrants, is that immigration detention is an administrative process. So, unlike the criminal system, in the administrative detention system of immigrants there is no judge who reviews the individual's detention. Detention typically is an administrative decision initially reviewed by Immigration and Customs Enforcement.

In some cases, an immigration judge may have an option to review that and set bond. But even if an immigration judge sets

bond, the Government has the option to stay that bond if it chooses to do so.

For example, I had a client for whom the immigration judge granted a $5,000 bond. The Government stayed that decision and the client remained detained for 3 years while seeking judicial review of the administrative decision.

Mr. ELLISON. So these are folks—I think it's important to be clear on the record, we are talking about people who are not even alleged to have harmed anyone or be a danger to the public. We are talking about people who are like Ms. Asfaw, for example, who had been a victim of political and physical torture herself, she is detained for, what, 5 months, was it?

Did the fact that she hadn't hurt anybody or wasn't a threat or it would even be cheaper for the Government to just let her be in the community, does that come up when the decisions about detention are evaluated?

Did that come up in your case, Ms. Asfaw?

Could somebody help her?

Ms. MCCARTHY. Yes, I can answer the question. I am not sure with respect to her case, but for asylum seekers in general the Government does have the option to review whether or not that individual should remain detained. So after the individual passes what's called a "credible fear" interview, the Government agency, ICE, could review whether or not Ms. Asfaw should have remained detained. And what ICE should consider is exactly what you mentioned: whether she's a flight risk or a danger to the community. But ICE has added another element to this review: whether or not it is in the public interest that the asylum seeker be released into the community. ICE added this irrelevant factor that makes it difficult for an asylum seeker to be released.

As lawyers representing asylum seekers, we identify sponsors and individuals who the asylum seeker could possibly be released to, and then advocate for their release. But even in those situations, where the detainee meets the criteria, ICE denies release of the asylum seeker and there is no judicial review of the decision. ICE has complete discretion over the asylum seeker's release.

Mr. ELLISON. Does the question of extant medical need ever arise in the detention-release calculus? I mean, if somebody has a serious medical problem and it'd brought to the attention of the decision-maker, does that mitigate in favor of them being released into the community where they can get their medical needs met?

Ms. MCCARTHY. It does, yes.

Mr. ELLISON. How often does that come up? It sounds like, based on the testimony we've heard, that it's not being very well heeded by the decision-maker. Am I wrong?

Ms. MCCARTHY. I think your point is well-taken. Yes, I think that's one of the issues. And I think Ms. Armendariz's case is a very strong example of that. Her husband continued to be detained des[ote his medical conditions. This case illustrates that that medical humanitarian factors are not taken seriously into consideration by ICE.

Mr. ELLISON. If we had judicial judges doing the evaluating, would we probably get better outcomes?

Ms. MCCARTHY. I think you're absolutely right. And, as Ms. Baker mentioned, she was ready to file a habeas petition in her client's case, which is an option, but there are many hurdles to habeas relief. So if we can build into the law some type of judicial review of the continued detention of the individual, I think that would be very valuable.

Mr. ELLISON. As Americans, we value liberty. We consider liberty an important value. It doesn't matter whether you are documented or undocumented. Whether you have a right to remain in the country is what is to be determined, right, later?

Ms. MCCARTHY. Absolutely.

Mr. ELLISON. So it seems to me a somewhat strange anomaly in the law that when it comes to people who are trying to enter the country, that we would have even less discretion than a criminal defendant, who at least there is some probable cause for.

Anyway, that's just my editorial.

Let me ask you this. What are the implications for overcrowding? What about when we get into jails, county jails, other kinds of facilities when people can't be at a detention facility, which I would imagine is somewhat suited to meet the need that it's designed for, what about the overflow when—I mean, do we have people who are immigrants waiting to be determined about their status——

Ms. LOFGREN. I will give Mr. Ellison an additional minute so that question can be answered.

Mr. ELLISON. Thank you, Madam Chair—in the county jails?

Ms. MCCARTHY. Well, Immigration and Customs Enforcement enters into contracts with county jails throughout the country. They have over 300.

Mr. ELLISON. Are they are mixed in?

Ms. MCCARTHY. There are occasions when the immigration detainees are mixed in with the criminal detainees, although the detention standards provide that they should not be mixed in. But what happens in reality is that due to the increase of the number of detainees, there is a great deal of overcrowding. You hear about people sleeping on the floor, people not having access to proper hygienic materials, as well as adequate food and proper treatment.

Mr. ELLISON. Thank you for your testimony.

Thank you, Madam Chair. I yield back.

Ms. LOFGREN. Thank you.

And thanks to all of the witnesses.

Mr. Harrison had to leave early to catch his flight, but we will certainly appreciate his offer of continuing help, Mr. Reyes as well, Bishop.

Ms. Armendariz, yes, certainly you can speak.

Ms. ARMENDARIZ. May I just make a point? Isaias had just served a year and a half in prison. I didn't see the point of keeping him in ICE. They could have saved money by him waiting for his hearing—he was on Social Security. Where was he going to go? They could find him. So I think it could have saved them money and wait for the process, and that shouldn't have happened. That could be one——

Ms. LOFGREN. Thank you. It would save the Government money and maybe be a little more respectful of that Vietnam-era vet.

I thank you, Ms. McCarthy, Dr. Venters, for your excellent suggestions.

Ms. Baker, it was fascinating to hear your story, and I hope that, in addition to doing IP litigation, you will have time to put your new knowledge of asylum cases to work again.

The record will remain open for 5 legislative days. We may have additional questions for you. If so, we will forward them to you and ask, if at all possible, that you respond promptly if that occurs.

With that, we will follow up with this hearing, as Mr. Conyers and Mr. King have agreed to solicit comments from Ms. Myers. We may need additional hearings, we don't know. But this is very serious to me, to hear these stories.

The GAO was not able, actually, to go in and do the study because of the litigation involved. But, certainly, we have received substantial information that there is a substantial problem. Everybody in America is entitled to due process of law, and I have very serious concerns about whether that is, in fact, occurring in this area of the law.

And, certainly, wherever we stand on the issue of immigration, we all need to know that there are civilized requirements for the Government when individuals are held in custody. Those people who are in custody don't have the option of going across town to their doctor any more than, you know, we have to feed them because they don't have the option of going across town to Burger King, too. So there are some obligations we undertake when we incarcerate. And, certainly, we need to take a look at what are the alternatives to that system.

So we do thank you for your patience with our voting schedule, for your important testimony.

And this hearing is now adjourned.

[Whereupon, at 6:15 p.m., the Subcommittee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

PREPARED STATEMENT OF KAREN LONG, RN, APN,C, CWOCN, MEMBER OF FIRST FRIENDS, ELIZABETH DETENTION CENTER VISITOR PROJECT, BOARD MEMBER OF THE INTERFAITH REFUGEE ACTION TEAM-ELIZABETH

I have been a visitor at the Elizabeth Detention Center for the past four years with an organization called First Friends. During this time I have met many detainees from all over the world in the same dire situation.

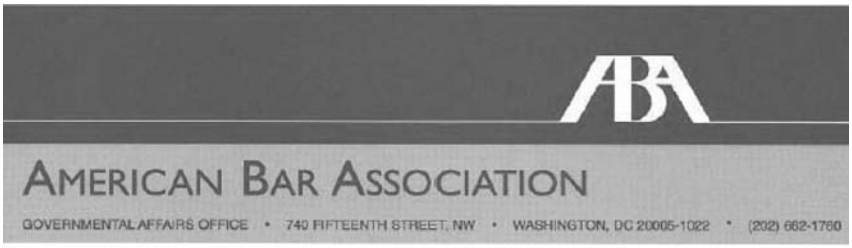
During these visits there were often health complaints which were usually minor such as a headache, generalized fatigue or stomach upset. I would often find myself telling the detainees that I was visiting that they should go to the medical clinic to get treatment. I said this even though I was sure I knew the answer. I would get a smirk of some sort and would be told something to the effect "Oh what's the use, they don't do anything for you anyway." Many would mention getting the "red pill" and being sent back to their dorm. Since these complaints never seemed emergent I just went on with my visit and wished them well.

The young woman I had visited most recently is from Liberia. She is 25 years old. She has documented evidence of Female Genital Mutilation (FGM), which unfortunately no longer holds weight with asylum cases. This young woman kept complaining of abdominal pain. She told me that when she went to the clinic at the EDC all they would do is give her some pills and send her back. While in her dorm, when she complained of continued pain, despite "treatment", she would be given an appointment for later that week.

As a nurse I began to be concerned that she could have a bleeding ulcer or some other abdominal pathology because she also was quite fatigued and was not getting any sleep. At one point when her case was being considered for parole I called down to the parole officer with my concern that she needed additional health care and if paroled I or a friend of hers would get her the care she needed.

She did eventually receive parole and at a nearby hospital was diagnosed with pelvic Inflammatory Disease (PID), a condition that if left untreated could cause fertility problems in the future. She continues to have gynecologic problems related to the FGM and will most likely need continued management.

Because of the personal nature of this story I choose not to tell her name. If the committee seeks further information from this young woman please let me know. I keep in touch with her and a family friend who continues to fight for her by spending thousands of dollars in legal fees attain asylum for her.



Statement of

WILLIAM H. NEUKOM, PRESIDENT

on behalf of the

AMERICAN BAR ASSOCIATION

submitted to the

SUBCOMMITTEE ON IMMIGRATION, CITIZENSHIP, REFUGEES, BORDER SECURITY AND INTERNATIONAL LAW

COMMITTEE ON JUDICIARY

of the

U.S. HOUSE OF REPRESENTATIVES

on the subject of

Problems with Immigration Detainee Medical Care

June 4, 2008

Chairwoman Lofgren, Ranking Member King and members of the Subcommittee:

On behalf of the American Bar Association, I am submitting this statement for your consideration as you examine the very serious issues related to adequate access to medical care for immigration detainees. We commend the subcommittee for continuing to focus on the urgent need for improvement in the provision of health care for individuals in immigration detention and appreciate this opportunity to share our views. The ABA believes detainees must be provided with a continuum of prompt, effective medical and dental care, to include both treatment and preventive services that are medically necessary, at no cost to the detainee. We recommend several steps, outlined below, that can and should be taken to assist in accomplishing this goal.

While several national news stories have heightened public awareness and focused attention on this issue in recent weeks, there have been ongoing, significant problems with the treatment of individuals in immigration detention for many years. The increasing reliance on detention, combined with enhanced enforcement activities, has resulted in a growing population of immigration detainees. Without concrete improvements to the system, the current problems with medical care, as well as other serious problems with detention conditions, will almost certainly be exacerbated in the future.

The ABA has worked for many years to ensure that foreign nationals in detention in the United States are treated fairly and humanely and that measures are in place to protect detainees' statutory and constitutional rights. During the late 1990s the ABA, along with other organizations, worked with the then-Immigration and Nationality Service (now Immigration and Customs Enforcement, or ICE) to develop the ICE National Detention Standards. The Standards, which took effect in January 2001, are comprehensive and encompass a diverse range of issues, including access to medical care.[1] As a key stakeholder in developing the Standards, the ABA is committed to their full and effective implementation. The ABA launched the Detention Standards Implementation Initiative, in a spirit of cooperation with ICE, to visit, tour, and report on observations of facilities across the country. To date, 107 ABA delegations have visited sixty-four different facilities holding ICE detainees.

The ABA also receives information relevant to detention conditions through written correspondence and telephone calls from detainees and advocates. Since 2003 we have received more than 1,300 letters from detainees at almost 200 facilities across the United States. In addition, issues are brought to our attention through our three *pro bono* programs that provide legal orientation presentations and representation to immigrants in detention: the South Texas Pro Bono Asylum Representation Project (ProBAR) in Harlingen, Texas; Volunteer Advocates for Immigrant Justice (VAIJ) in Seattle, Washington; and the Immigration Justice Project (IJP) of San Diego in California.

It is clear that despite the existence of the Detention Standards and the efforts of ICE, the ABA, and others to oversee their implementation, immigration detainees continue to face challenging,

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[1] The majority of the Standards were issued and signed on September 20, 2000, and there have been a few updates and standards added in 2002, 2003, and 2004. ICE is currently in the process of redrafting the Detention Standards. Detention Standards as referenced in this statement refers to the standards that are currently in effect and available in the ICE Detention Operations Manual at http://www.ice.gov/partners/dro/opsmanual/index.htm.

sometimes life-threatening, conditions in detention. Complaints the ABA has received from immigration detainees that directly or indirectly relate to detainee health and access to medical care include: (1) medical complaints, including medication not being received in a timely fashion, delayed treatment, and pain relievers offered in response to any complaint regardless of its nature; (2) dental complaints, including that serious tooth pain, gum problems, or other issues are treated with over-the-counter pain relievers or tooth extraction rather than preventive care and routine treatment; (3) unsanitary conditions, including rodents in housing areas; (4) insufficient food, or food not meeting medical diet needs; and (5) lack of information about grievance procedures, as well as grievance procedures not being followed (including complaints not being answered and detainees being threatened with losing privileges, being reclassified, or being transferred for filing grievances).

From the many letters the ABA receives that describe problems with medical care, we draw two examples. A woman detained from October 2006 to November 2007 at three different facilities (Laredo Processing Center in Laredo, Texas, an IGSA facility operated by Corrections Corporation of America; South Texas Detention Complex, in Pearsall, Texas, a Contract Detention Facility operated by The GEO Group, Inc. under contract with ICE; and Port Isabel Detention Facility, an ICE Service Processing Center in Los Fresnos, Texas) wrote to the ABA beginning in June 2007 that she was afraid she would die in detention because she had been sick and bleeding vaginally since February 2007, and had other health problems including a hernia and back pain, but was denied treatment. She wrote that she saw a doctor on March 21, 2007 who told her she needed a sonogram and surgery to correct the bleeding problem. She had a sonogram on April 10, 2007, which revealed tumors in her uterus and a cyst in one ovary. Again a doctor recommended surgery based on the sonogram. However, Laredo Processing Center only provided her with pain relievers. After several months of filing grievances and writing to the DHS OIG, the DHS Office for Civil Rights and Civil Liberties, and advocacy organizations, she was finally scheduled for surgery in October 2007. The Director of ProBAR wrote to ICE in late October requesting that she be released on an order of supervision in order to have the complete hysterectomy that she required, and she was subsequently released on an order of supervision.

A man who was detained at Bristol County Jail, an IGSA facility in North Dartmouth, Massachusetts, wrote that he feared for his life and described his medical treatment in letters written in December 2007 and January 2008. He wrote that he is diabetic and requires dialysis as well as treatment for high blood pressure. During his arrest in November 2007 and transport to the detention facility, a process that apparently took some time, ICE denied him his medication and he became sick. At Bristol County Jail, he told officers that he was very ill but was told to "stop faking it." A nurse who found that his blood pressure and blood sugar were elevated told him that there was nothing she could do until they got him into the system. Eventually officers took him to St. Luke's Hospital in New Bedford, Massachusetts, where he remained for nine days. A doctor told him he could have died. A social worker had ICE sign an agreement that they would make sure he could have his dialysis. When he was returned to Bristol County Jail, to a cell in the medical unit with a mattress on the floor and no blankets, and again had medical problems, he asked an officer for medical attention and was told to just go back to his country. In January 2008 he wrote that when he was pleading for help on January 2, 2008, because he was ill and vomiting on the floor of his cell in the medical unit, officers made fun of him and threatened to do something worse to him than leave him in a cold, filthy cell if he continued banging on the door. A nurse who came in later

to administer medication reduced the number of pills that he had been prescribed, and when he told her how many he should have, she told him that she was the doctor now. This man is apparently no longer detained at Bristol County Jail.

Many of the concerns identified by the ABA very closely resemble issues raised in recent reports by the DHS Office of Inspector General and the Government Accountability Office.[2] In December 2006, the DHS OIG identified several instances of noncompliance with medical care standards at four of the five facilities it investigated.[3] Noncompliance included failure to consistently conduct the initial medical screening required for new detainees or the health appraisal and physical exam required within fourteen days, failure to timely respond to sick call requests, failure to comply with hunger strike standards, and failure to provide documentation regarding suicide prevention and intervention.[4] According to the GAO report, the U.S. Public Health Service staff providing medical services for the San Diego Correctional Facility was cited by ICE reviewers for "failing to administer the mandatory 14-day physical exam to approximately 260 detainees."[5] The process for responding to requests for medical care can be cumbersome, time-consuming, and dangerous to those who are waiting for care.[6]

It has become clear that the lack of a legal enforcement mechanism has seriously undermined the effectiveness of the Standards, and that in turn has contributed to the deficiency of medical care provided to detainees in some circumstances. For this reason, the ABA has joined in urging the Department of Homeland Security to promulgate the Detention Standards as regulations. While DHS has not yet made a final determination on this issue, in an initial response to our request Secretary Michael Chertoff expressed reservations with moving toward adopting regulations, stating agency flexibility would be undermined. Cabining agency "flexibility" in cases of medical emergencies and extreme health conditions is, of course, the very purpose of this recommendation.

The ABA therefore also welcomes legislative initiatives, such as H.R. 5950, the Detainee Basic Medical Care Act, which would require the Secretary of Homeland Security to establish procedures for the timely and effective delivery of medical and mental health care to all immigration detainees. We are particularly pleased to note the bill's requirement that such procedures take into account all detainee health needs including primary care, dental care, eye care, mental health care, medical dietary needs, and other specialized care. We urge Congress to adopt this legislation, as well as other proposals to improve detention conditions, as soon as possible.

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[2] The OIG report, "Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities" (OIG-07-01, Dec. 2006) (hereinafter OIG 2006 report), is available at http://www.dhs.gov/xoig/assets/mgmtrpts/OIG_07-01_Dec06.pdf. The GAO report, "Alien Detention Standards: Telephone Access Problems Were Pervasive at Detention Facilities; Other Deficiencies Did Not Show a Pattern of Noncompliance," GAO-07-875 (July 2007) (hereinafter GAO 2007 report) is available at http://www.gao.gov/new.items/d07875.pdf. For more detail regarding immigration detention complaints, see *Orantes-Hernandez v. Gonzales*, 504 F.Supp.2d 825 (C.D. Cal. Jul. 26, 2007) (upholding nationwide injunction based on record documenting violations of provisions of the injunction concerning detention conditions problems including problems with access to law libraries and legal materials, telephone use, attorney visits, and other detention standards issues).

[3] OIG 2006 report at 4.

[4] OIG 2006 report at 3-4, 5, 5-6.

[5] GAO 2007 report at 18.

[6] See *Castaneda v. U.S*, Complaint and Demand for Jury Trial, C.D. Cal. (Oct. 31, 2007), available at http://www.bibdaily.com/pdfs/Castenada%20Complaint%20(10.31.07).pdf.

It also is imperative that oversight of Detention Standards implementation be improved. Currently, ICE inspects facilities once per year and rates the facilities' compliance with the Standards. In 2007, ICE established a process to provide semi-annual reports on the findings of the annual inspections and provide discussion of necessary remediation and corrective actions.[7] While this is a positive step, it does not obviate the need for oversight reviews and reports on the adequacy of the inspection process itself and of individual inspection reports. We note that a Detention Facilities Inspection Group (DFIG) has been established within the ICE Office of Professional Responsibility (OPR)[8] and is intended to provide objective oversight of the detention facility inspection program, including by independently validating detention inspections for non-compliance with the Detention Standards. However, we understand the DFIG may be understaffed and lacks the resources to review more than a selection of inspection reports, and must prioritize the facilities that hold larger numbers of detainees. This leaves an enormous gap in oversight, especially at facilities such as remote local jails that may be particularly in need of oversight and review. The ABA urges that the OPR DFIG be provided with adequate resources to review *all* detention facility inspection reports and to make public its findings.

The ABA also supports providing in-depth training on the Detention Standards, as well as periodic training updates, to all persons who supervise, are responsible for, or otherwise come into regular contact with immigration detainees, including ICE officers, contractors, and state, local, and federal corrections and related personnel. Although ICE has undertaken efforts to train its own personnel to enforce the Detention Standards, similar training is not provided for non-ICE personnel, including wardens and staff at state and local jails—the Intergovernmental Service Agreement (IGSA) facilities.[9] Since these facilities house 65%[10] of immigration detainees, this gap in training must be corrected. If ICE is unable to ensure that facility staff charged with supervision and care of immigration detainees are trained in how to follow the Detention Standards, it must seek alternatives to detaining noncitizens in these facilities.

The effective implementation of not only the Medical Care Standard, but all of the Detention Standards, has the potential to impact the accessibility and quality of medical care for detainees. For example, detainees must be provided comprehensive information on how to request medical assistance at the facility in which they are held, and in a language that they can understand; detainees must be assured that they will not face retaliation if they file a grievance for lack of care; all appropriate medical records and medication must accompany detainees who are transferred between detention facilities; detainees, particularly those with chronic health issues, should not be transferred to remote locations where specialized health services may be less accessible; access to telephones and visitation by family members must be maintained so that health issues that might not be otherwise identified or recognized by the facility may be made known to family members, attorneys, and others who may be able to help ensure the issues are appropriately addressed.

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[7] On May 9, 2008 ICE released "Protecting the Homeland: Semiannual Report on Compliance with ICE National Detention Standards January – June 2007."

[8] U.S. Senate Committee on Homeland Security and Governmental Affairs Pre-hearing Questionnaire For the Nomination of Julie Myers to be Assistant Secretary, Department of Homeland Security, at 59.

[9] Senator Kennedy Follow-up Questions, at 2.

[10] Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law Hearing, "Detention and Removal: Immigration Detainee Medical Care," (Oct. 4, 2007), comments of Representative Steve King on information provided to the Committee by ICE.

Though the issue may be beyond the scope of today's hearing, we would also note one additional measure that could help alleviate the pressures, and accompanying problems, of providing health care services to an increasingly large detained population—the use of affordable, effective alternatives to detention. The ABA has long opposed detention of noncitizens except in extraordinary circumstances (such as when there is a substantial flight risk or threat to national security or public safety), and supports humane alternatives to detention that are the least restrictive necessary to ensure that noncitizens appear in their immigration proceedings. Placing detainees with serious medical conditions, as well as other particularly vulnerable detainees, in alternative settings will both benefit the individual detainees and alleviate some of the demands on the health care system.

The ABA is deeply concerned about the state of immigration detention in the U.S. and emphasizes particularly the need for accountability to ensure that detainees are treated fairly and humanely. As stated above, we believe that a number of steps should be taken to address these concerns, including: promulgating the ICE Detention Standards as regulations; periodically reviewing and improving the Standards; creating an oversight office within DHS; providing appropriate training for detention facility personnel; utilizing humane alternatives to detention; and providing detention bed space in populated areas where appropriate medical care may be more readily available and communication with family members and legal representatives can be easily maintained. We believe each of these steps would significantly increase immigration detainees' access to timely and effective medical care, and would also help address other serious problems in our immigration detention system.

Thank you, again, for this opportunity to share our views.

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Written Statement
For a Hearing on

"Problems with Immigration Detainee Medical Care"

Submitted to the House Judiciary Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law

Wednesday, June 4, 2008

Caroline Fredrickson, Director
ACLU Washington Legislative Office

Tom Jawetz, Immigration Detention Staff Attorney
ACLU National Prison Project

The ACLU welcomes this opportunity to present to the House Judiciary Subcommittee on Immigration, Citizenship, Refugees, Border Security, and International Law our written testimony about grossly inadequate medical care provided to immigration detainees and our support for H.R. 5950, the Detainee Basic Medical Care Act of 2008, which would improve medical care for this vulnerable population.

I. Introduction

The American Civil Liberties Union ("ACLU") is a nationwide, non-partisan organization dedicated to the principles of liberty and equality embodied in our Constitution and our civil rights laws. It is the largest civil liberties organization in the country, with offices in 50 states and over 500,000 members. Consistent with its mission, the ACLU established the National Prison Project ("NPP") in 1972 to protect and promote the civil and constitutional rights of people in detention. The NPP is the only program in the United States that litigates conditions of confinement cases on a national basis; at any given time we have cases pending in 20 to 25 states.
Immigration and Customs Enforcement ("ICE") was created in 2003 as part of the creation of the Department of Homeland Security ("DHS"). ICE is responsible for, *inter alia*, overseeing the detention of persons charged with violating U.S. administrative immigration laws. In recent years, the use of immigration detention has skyrocketed, making immigration detention the fastest growing form of incarceration in this country. As a result, the NPP has developed an immigration detention initiative to protect the rights of this frequently unrepresented population.
During the past year, staff from the NPP have visited six facilities that together house more than 6,000 ICE detainees on any given day; staff from other ACLU projects and offices have visited many other ICE detention facilities. The NPP receives dozens of complaints from detainees, their family members, or other advocates about ICE detention conditions each

month. NPP staff advocate on behalf of individuals in ICE detention and have brought three lawsuits against ICE facilities for failing to meet legally-mandated standards regarding living conditions for detainees. Through its efforts, the NPP has come in contact with many hundreds of ICE detainees.

II. The People in ICE Detention

Each year more than 300,000 people are taken into ICE custody.[1] On any given day, there are approximately 33,000 people in ICE detention,[2] including persons who are not security threats or flight risks; who are hardworking and came to the United States in search of the American Dream and the freedoms that this country offers; and who are particularly vulnerable, including asylum-seekers, torture survivors, and children. A person can end up in ICE custody simply because she arrived at the airport and asked to be protected from torture back home. Long-time lawful permanent residents of the United States can be detained—and ultimately deported—because of minor criminal convictions from 30 years prior, notwithstanding the fact that they have already served whatever criminal time they may have received for the offense. Not a single person in ICE custody is serving time for a criminal conviction.

More than 40% of immigration detainees are held in hundreds of local jails all around the United States. Although they are not charged with having committed any crime, they are held in facilities with criminal detainees, and are sometimes intermingled with that population. Many ICE detainees are held for weeks, others for months or years. We have received complaints from detainees who are often subjected to arbitrary punishment, including shackling, solitary confinement, neglect of basic medical and hygienic needs, denial of outdoor recreation, and verbal, physical and even sexual abuse.

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[1] Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

[2] *Id.*

Unlike persons charged with criminal offenses, immigration detainees have no right to appointed counsel paid by the government. As a result, approximately 90 percent of immigration detainees are forced to defend themselves and their right to enter or remain in the United States against a trained DHS trial attorney charged with prosecuting their deportation case.[3] People held in ICE detention are frequently detained in facilities far from their homes, families, friends, co-workers, and neighbors. Therefore, they rarely have people on the outside to help advocate for them.

In addition, many immigration detainees fear retaliation for filing complaints about detention conditions, including deplorable medical care, because they are fighting their removal in immigration court. Many people are afraid they will be deported if they raise concerns with ICE officials about their detention. Finally, countless ICE detainees face language barriers, as English is frequently not their first language. Because of these factors unique to people in immigration detention, we are deeply concerned that the vast majority of this population is without a voice, and that the complaints that we have received, particularly about medical care, are just the tip of the iceberg.

III. ACLU Efforts to Protect the Rights and Human Dignity of ICE Detainees

A. ACLU Litigation

In January 2007, the ACLU brought a class action lawsuit on behalf of ICE detainees at the San Diego Correctional Facility ("SDCF"), charging that chronically severe overcrowding at the facility was placing detainees' health and safety at risk, in violation of the Fifth Amendment to the U.S. Constitution.[4] SDCF is a contract detention facility operated by Corrections Corporation of America, Inc. ("CCA"), the largest private, for-profit provider of detention and corrections services in the nation. At the time the lawsuit was filed, the facility held approximately 1,000 ICE detainees.

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[3] *Id.*

[4] *Kiniti v. Myers*, No. 05-cv-1013 (S.D. Cal.).

Approximately 675 detainees—more than two thirds of the ICE population at SDCF—were housed in pods that were triple-celled, meaning that three detainees were assigned to sleep and spend significant blocks of time during the day in small cells designed for two people. As a result, hundreds of detainees slept on plastic "boats" on the floor next to the toilet or crammed under bunk beds. Additional detainees slept in the common dayroom space. Within three days of the ACLU's appearance in the case, ICE officials transferred more than 100 detainees out of the facility.

In March 2007, the ACLU filed a series of lawsuits on behalf of children held by ICE at the Hutto Detention Center in Taylor, Texas.[5] ICE uses the Hutto facility, managed by CCA, to detain entire families, including infants; the facility was previously used by CCA as a medium-security adult prison. The lawsuits charged that ICE violated its duty to meet the legal standards for the housing and release of all minors in federal immigration custody. The ACLU's original 10 plaintiffs included children as young as three who were forced to wear prison jumpsuits and live in prison-like cells. They had little access to education or exercise. No pediatrician was available on-site, and children did not receive timely physical examinations or screenings for infectious diseases.

In August 2007, the lawsuit was settled and major improvements were required as part of the settlement. Children are no longer required to wear prison uniforms and are allowed much more time outdoors. Educational programming has expanded, and guards have been instructed not to discipline children by threatening to separate them from their parents. In addition to making those improvements permanent, the settlement also requires ICE, among other things, to allow children over the age of 12 to move freely about the facility; provide a full-time, on-site pediatrician; eliminate the count system that forced families to stay in their cells 12 hours a day; install privacy curtains around toilets; and improve the nutritional

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[5] *In re Hutto Family Detention Center*, No. 07-cv-164 (W.D. Tex.).

value of food. ICE must also allow regular legal orientation programs by local immigrants' rights organizations. ICE's compliance with each of these reforms, as well as other conditions reforms, is subject to external oversight to ensure their permanence.

In June 2007, the NPP filed a class action lawsuit on behalf of ICE detainees at SDCF for the facility's failure to provide necessary medical and mental health care.[6] SDCF detainees are routinely subjected to long delays before treatment, denied necessary medication for chronic illnesses, and refused essential referrals prescribed by medical staff. The lawsuit specifically names 11 detainees, including a woman refused treatment for a neurological disorder that has caused painful tumors to develop; detainees with untreated bipolar disorder and depression; and detainees with chronic health conditions such as Type 2 diabetes, hypercholesterolemia and hypertension that are inadequately monitored. The San Diego facility was prominently featured in the *Washington Post*'s four-part series on inadequate medical care for ICE detainees that ran in May 2008.[7] SDCF was the location where one detainee's cancer was allowed to spread undiagnosed and untreated for eight months, another detainee developed gangrene and a potentially fatal bone infection before being rushed to the emergency room after suffering through four weeks of neglect, and a third detainee died in his cell while his cellmate's cries for help were ignored by both correctional officers and medical personnel.

B. ACLU Visits to ICE Detention Facilities in South Texas

In recent months ACLU staff members have traveled to south Texas on several occasions to interview dozens of immigration detainees at three

[6] *Woods v. Myers*, No. 07-cv-1078 (S.D. Cal.).

[7] Dana Priest and Amy Goldstein, *Careless Detention: Medical Care in Immigrant Prisons*, WASHINGTON POST, May 11-14, 2008, available at http://www.washingtonpost.com/carelessdetention.

immigration detention facilities.[8] On May 7 and 8, 2008, the visits also included guided tours of all three facilities. ACLU staff visited the Port Isabel Service Processing Center ("Port Isabel SPC"), the Willacy County Detention Center ("Willacy"), and the South Texas Detention Complex ("STDC"). Although the Port Isabel SPC is operated by ICE, both Willacy and STDC are operated by private, for-profit corrections companies. Medical care at all three facilities is directly provided by the Division of Immigration Health Services ("DIHS").

Together, the three facilities house more than 5,000 detainees on any given day—that is, more than 15 percent of all ICE detainees in the country. The Willacy facility—which is already the country's largest ICE facility, housing 2,000 detainees in tents—is expected to house an additional 1,000 detainees as soon as this month.

The *Washington Post*'s four-part series, *Careless Detention*, revealed serious problems with health care at two of the three facilities. According to the *Post*, the Willacy facility "has no clinical director, no pharmacist, and only a part-time psychiatrist."[9] In the summer of 2007 the facility was hit by an outbreak of chicken pox caused by poor disease screening and a lack of education about how to prevent the spread of infectious diseases.[10] At the STDC the medical unit in January 2008 had a backlog of 2,097 appointments.[11] As of June 2007, the Chief of Psychiatry for DIHS identified a "crisis in the mental health care at [STDC]," with more than 140 patients awaiting chart review by the facility's clinical director who appeared to be refusing to provide mental health care outright.[12]

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[8] These visits were conducted by ACLU staff from the Immigrants' Rights Project, National Prison Project, Human Rights Program, and Racial Justice Program, as well as staff from the ACLU of Texas and the ACLU of New Mexico.

[9] Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

[10] *Id.*

[11] *Id.*

The ACLU's findings largely mirrored those of the *Washington Post*. During our tour of the medical facilities at the Port Isabel SPC, we were informed that approximately 40 percent of the medical positions are currently unfilled. The facility—which houses 1200 detainees—employs only one staff physician. At the time of our visit, the facility's other position for a staff physician had been unfilled since March 2007 (*i.e.*, more than 14 months). At the Willacy facility we were not told how many medical staff positions were currently vacant. However, we were informed that for 2,000 detainees—soon to be 3,000 detainees—there was only one dentist, one staff physician, and one part-time psychiatrist. A simple search on the DIHS website shows that since 2007, the facility has been trying to hire a clinical director, staff physician, pharmacist, pharmacy technician, dentist, dental assistant, psychiatrist, medical records technician, and various nursing positions.[13] At STDC the problems appeared even more stark. At the time of our visit, the facility of 1900 detainees had no dentist, no staff physician, minimal nursing support, and neither a psychiatrist nor a psychologist on-site. The facility, which was also missing a Health Services Administrator, estimated that only 50 to 60 percent of the medical staffing positions were filled, and that only one registered nurse and two licensed vocational nurses remained on duty each night.

Both Port Isabel SPC and Willacy are more than 230 miles from San Antonio, the nearest city of note. Even Pearsall is a one-hour drive from San Antonio. Because of the remote locations of these three facilities, the percentage of immigration detainees who are represented by counsel is minuscule. Not only does the lack of counsel typically doom the possibility of prevailing in immigration court, but it often means that no one outside of the detention facility is advocating for necessary detainee health care.

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[12] Dana Priest and Amy Goldstein, *Suicides Point to Gaps in Treatment*, WASHINGTON POST, May 13, 2008.

[13] Division of Immigration Health Services, Job Openings, at http://jobs-dihs.icims.com/dihs_jobs/jobs/candidate/intro.jsp (last visited May 29, 2008).

C. Individual Stories from ICE Detainees held in South Texas

During our visits to the facilities—which occurred just days before the *Washington Post*'s investigative series ran in May 2008—the ACLU met with many detainees suffering from serious health problems who reported gross neglect. While these stories have not been vetted to the same extent as those appearing in the *Washington Post*, there is a lesson to be learned here. Unlike 90 percent of immigration detainees who are never represented by counsel, virtually every detainee whose story was profiled in the *Washington Post* series was represented. It was through the efforts of these attorneys that medical records were obtained, grievances were submitted, and letters demanding release from custody were filed. The level of medical neglect experienced by these detainees is not exceptional; what is exceptional is the fact that the public was ever able to learn of their abuse in such detail. The following stories were collected by the ACLU through interviews with detainees at two of the facilities in south Texas.

South Texas Detention Complex:

- In May 2007, Mr. D.1. was detained at the Santa Ana detention facility in California where he fell and seriously injured his shoulder. When he saw medical staff at the facility, he was given medication for the pain but no other treatment. Approximately eight days later, after he complained that he was unable to move as a result of the fall, he was transferred to the San Pedro Service Processing Center ("San Pedro SPC"), a detention facility where DIHS provides medical care to detainees. He was taken to an outside hospital, where he received an MRI and was told that he would require surgery to repair the injury. But before he could get the surgery, he would need DIHS approval. Mr. D.1. was then transferred to the El Centro Service Processing Center ("El Centro SPC"), another California facility where DIHS provides medical care. While at the El Centro SPC, Mr. D.1. developed a serious eye infection that resulted in itching and pus. He was eventually transferred back to the San Pedro SPC to

receive treatment, but the on-site physician told him that he did not have the appropriate equipment to check Mr. D.1.'s eyes. Mr. D.1. was sent to have his eyes examined, and he was informed that his nerves were damaged. He was prescribed eye drops for treatment. Mr. D.1. was then transferred to STDC in Pearsall, Texas, where he arrived with three medications: prescription eye drops, Tylenol, and medication for his recently-diagnosed diabetes. During intake, Mr. D.1. was given only Tylenol, but did not receive his eye drops until 15 days after his arrival and did not receive his diabetes medication until 30 days after his arrival. At the time ACLU staff members visited STDC in March, Mr. D.1. was wearing dark glasses to protect his eyes from light and had a very difficult time keeping his eyes open without his glasses. In a recent letter to the ACLU from Mr. D.1., he explains that he is "going blind," and that his requests for medical attention have yielded no additional care.

- Ms. D.2. is an HIV-positive, transgender woman who was transferred to the STDC from the San Pedro SPC. After her transfer, approximately eight days passed before she received the medications she had been taking to manage her disease. Shortly before our visit to the facility in March 2006, she stopped taking her medications because of the harsh side effects the medications were causing, including diarrhea and inability to eat or keep any food in her stomach. Despite submitting several requests to have her medication modified, she has received little attention by the medical staff.

- Mr. D.3. speaks neither English nor Spanish, and requires the use of an interpreter to communicate. He was originally detained in the Santa Ana facility in California, and was later transferred to the San Pedro SPC. At San Pedro, the treating physician informed him that his thyroid cancer had returned and he was provided with some medication. After being transferred to STDC, he had to wait more

than one month to resume his medication. During the time Mr. D.3. was not receiving his medication, he experienced serious pain in his throat and would hold his neck with his hand. Staff at the facility mistook this gesture as an indication that he was suffering from mental health problems, and referred him to a social worker. When Mr. D.3. finally met with the facility doctor, he was told that he did not have cancer, but he was prescribed medication that he was supposed to take twice daily for the rest of his life. After his lawyers began to complain about his deteriorating health, Mr. D.3. was given a blood test, but he was never told the results. As of our visit in March 2008, he had been waiting for four months to get a response to the daily medical requests he had been filing. He had regularly complained of back and arm pain, bleeding gums, a swollen hand, and the fact that he was coughing up blood every few days.

- Mr. D.4. was diagnosed as HIV-positive two years ago. Before entering detention, he would have his blood checked every one or two months and was prescribed a combination of three antiretroviral medications. After he was transferred to STDC from the San Pedro SPC, his medications were interrupted for two days. The last time his blood was drawn at STDC was approximately five months prior to our visit. He never received the results of that blood test. In January 2008, he and several other HIV-positive detainees were taken to an HIV clinic in San Antonio. Once there he met a doctor who informed him of his T-cell count and viral load, and asked that he return in March. As of May he had not yet been scheduled to return to the clinic and had not had another blood test. Mr. D.4. reported that another detainee living with HIV refused his medications because he believed he was having an allergic reaction to them. Dr. Johnson, STDC's Clinical Director, verbally abused the

detainee, and threatened to have him placed in restraints and sent to a segregation cell for refusing his medications.[14]

Port Isabel Service Processing Center:

- Ms. D.5 has been detained since January 2006. While in detention, she was diagnosed with diabetes and anemia. Initially she was provided no treatment for her diabetes, and she began to file multiple medical requests. When she was seen, her blood sugar level was found to be dangerously high, and she reported going blind for 15 days. The medical person who saw her confirmed that if she had continued like this, she would have gone into a coma or cardiac arrest. Ms. D.5. now requires insulin twice daily and receives additional medication for her kidneys and hypertension.

- Mr. D.6. entered ICE custody on September 2007. He was originally detained in the San Pedro SPC, was moved to STDC, and is now detained at the Port Isabel SPC. Mr. D.6 is HIV-positive and has also been diagnosed with herpes and depression. He received some initial blood tests at the San Pedro SPC, but he was scheduled to receive additional tests to determine his T-cell count and viral load at the time he was transferred to Texas. Since arriving in Texas in October 2007, he has had his blood drawn only two times, but he has not been told the results of the tests. The purpose of testing his blood is to determine what medication regimen Mr. D.6. requires to manage his HIV. He is currently receiving no medication for his HIV and is receiving medication only for herpes and depression. He

[14] Dr. Johnson's apparent refusal to provide medical care to detainees at STDC is heavily documented in the *Washington Post*'s story on mental health care in immigration detention. The *Washington Post* obtained internal emails from two supervisory officials within DIHS, including the chief of psychiatry who performs telepsychiatric services to STDC detainees from his office in Miami, Florida. In one email, the top mental health official in DIHS suggested that the DIHS medical director "issue a clear order for Dr. Johnson to begin to provide treatment to mentally ill detainees. . . . If he fails to follow the order, then this behavior needs to be interpreted as insolence and insubordination and documented as such." Dana Priest and Amy Goldstein, *Suicides Point to Gaps in Treatment*, WASHINGTON POST, May 13, 2008.

informed us that he frequently gets sick and requires medical attention.

IV. Systemic Problems with Medical Care in ICE Detention

This section outlines the major problems with medical care in ICE detention that the ACLU and others have identified. It also includes details about how H.R. 5950, the Detainee Basic Medical Care Act of 2008, will help alleviate some of these problems.

Problem: People in ICE Detention are Regularly Denied Basic Medical Care

ICE has promulgated 38 detention standards, which cover issues such as medical care, environmental health and safety, and use of force. But these standards are completely unenforceable and are regularly violated. This conclusion is based not simply on the ACLU's experience, which is derived from direct communication with detainees around the country, but on independent sources. In December 2006 the DHS Office of Inspector General ("OIG") issued a report on the treatment of ICE detainees.[15] According to the report, the OIG observed instances of non-compliance with the detention standards at all five facilities reviewed.[16] The OIG specifically noted serious failures in the medical care programs at four of the five facilities, including SDCF.[17]

In July 2007 the U.S. Government Accountability Office ("GAO") issued a report that similarly identified violations of the detention standards at various detention facilities around the country.[18] The GAO report

[15] U.S. Department of Homeland Security, Office of Inspector General, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, OIG-07-07 (Dec. 2006) (hereinafter the "OIG Audit Report").

[16] *Id.* at 1.

[17] *Id.*

highlighted deficiencies in the provision of medical care to detainees at several facilities.[19] The ACLU receives complaints from ICE detainees from around the country who are not receiving adequate medical treatment. They complain about long delays in treatment, incorrect prescription medications, and refusals to provide necessary specialty care. Our conclusion, based upon decades of advocating for the humane and just treatment of incarcerated persons, is that immigration detainees around the country are at risk of avoidable suffering, and even death, because of ICE's failure to ensure that they receive necessary medical and mental health care.

Fix: Congress Must Pass H.R. 5950, the Detainee Basic Medical Care Act of 2008

The Detainee Basic Medical Care Act of 2008 requires DHS to develop policies and procedures to provide ICE detainees with adequate medical care.

Problem: Untimely and Inadequate Medical Screenings Upon Intake

The OIG's December 2006 audit report found that more than half of the detainees at SDCF whose files were reviewed did not receive a physical examination within two weeks of arriving at the facility.[20] The *Washington Post*'s exhaustive investigation into medical neglect in ICE facilities similarly found failures to properly detect and contain infectious diseases such as tuberculosis and chicken pox at the outset, before they have an opportunity to spread to other detainees and members of the detention staff.[21] When a person enters a detention facility, it is critical that he receive a comprehensive initial screening, and a follow-up health assessment, by a qualified health care professional. The purpose of these examinations is to

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[18] U.S. Government Accountability Office, *Alien Detention Standards: Telephone Access Problems Were Pervasive at Detention Facilities; Other Deficiencies Did Not Show a Pattern of Noncompliance*, GAO-07-875 (July 2007).

[19] *Id.* at 5.

[20] OIG Audit Report at 4.

[21] Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

identify the detainee's serious health needs to ensure proper treatment as well as continuity of care throughout the detention process.

Fix: Procedures to Ensure Timely Medical Screenings and Examinations

The Detainee Basic Medical Care Act of 2008 requires DHS to develop procedures to ensure that upon intake, ICE detainees receive a thorough screening by a qualified health care professional and a follow-up examination and assessment within 14 days of arrival.

Problem: Gaps in Treatment

When a person arrives at an immigration detention facility with prescription medications, those medications are routinely confiscated as contraband by correctional personnel with no medical training. This is generally true even when a detainee was prescribed the medication at an earlier detention facility from which he has just been transferred. The result of this practice, when combined with the delays that detainees often face in seeing a physician capable of writing a new prescription, is that detainees often experience drastic interruptions in their treatment of serious health conditions.

The NPP has spoken with detainees suffering from chronic conditions such as hypertension, hypercholesterolemia, and seizure disorders who were unable to continue their medication regimens because of this practice. The dire consequences of interrupting treatment are particularly serious for people living with HIV. It is common knowledge that persons who take antiretroviral medications can quickly develop a permanent resistance to a particular medication if the medication regimen is interrupted. Yet many HIV positive detainees report serious delays in getting their medications upon intake to a new detention facility.

Even when a detainee has been properly diagnosed with a serious medical problem and prescribed medication at a facility, there is still no guarantee that proper treatment will be provided. Detainees typically rely upon medical or correctional personnel to deliver their medications on a timely

basis, and to ensure that prescription refills are ordered to prevent treatment interruptions. Yet detainees at several facilities report that prescription medications are often provided in a haphazard manner, with delays of several days or weeks in between prescription refills.

Last year, when the ACLU was investigating poor medical care at the SDCF in preparation for a class action lawsuit, we learned about a detainee whose leg was rotting and had been causing a putrid smell in his housing unit for several weeks. After numerous requests for medical attention, the man—Martin Hernandez Banderas—was taken to the facility's medical unit and diagnosed with uncontrolled diabetes and a diabetic ulcer that had become gangrenous. Although Timothy Shack, the former Medical Director for DIHS, stated publicly that Mr. Banderas received 24-hour care and was not among the general population, this was completely untrue.[22] After eight days of intravenous antibiotics in the facility's medical unit, Mr. Banderas was returned to the general population for the next four weeks, where his diabetes continued to go largely unchecked and he was not even given assistance over the weekend in changing the dressings on his wound. When Mr. Banderas was finally taken to the emergency room, doctors found that he still had gangrene in his foot and leg and had developed a potentially fatal bone infection. For several days in a row, medical staff at SDCF described his leg as emitting "a normal, healthy tissue type odor" and showing "no sign of active infection, pus or purulence." But when he arrived at the hospital just two days later, doctors observed a "large right leg/foot ulceration . . . deep, with foul smelling and yellow drainage." Doctors advised Mr. Banderas that to save his life, he might have to lose his foot. Fortunately for him, it did not come to that.

Fix: Procedures to Ensure Continuity of Care

The Detainee Basic Medical Care Act of 2008 requires DHS to develop procedures to ensure continuity of care. Beginning with

[22] Darryl Fears, *Illegal Immigrants Received Poor Care in Jail, Lawyers Say*, WASHINGTON POST, June 13, 2007.

intake, and ending with transfer, release, or removal, detainees should not experience delays or gaps in necessary treatment. Instead of allowing correctional officers without medical training to effectively deny a detainee prescriptions medications upon intake, the bill will place the decision to terminate a particular treatment in the hands of a qualified health care professional who has examined the detainee. The bill also requires DHS to design procedures to ensure that prescribed medications are provided on schedule and without interruption, and that a detainee's serious health needs are considered when contemplating the transfer of a detainee from one facility to another.

Problem: People with Serious Medical Conditions Are Unnecessarily Detained

People who are suffering from serious medical and mental health problems are particularly at risk of neglect and abuse in immigration custody. Reverend Joseph Dantica, an 81-year-old Baptist minister from Haiti, was taken into custody at the Miami airport in 2004 despite the fact that he possessed a valid visa and had routinely traveled between the United States and Haiti without ever overstaying a visa. The sole reason he was detained in 2004 was that he fled gang violence in Haiti and applied for asylum in the U.S. Rev. Dantica was detained despite the fact that he had serious health problems, including hypertension and an inflamed prostate. He died in detention shortly thereafter.

Sandra Marina Kenley was a lawful permanent resident for nearly 33 years. In 2005 she was stopped at the airport in connection with old, minor criminal charges, and was asked to appear at another ICE office to answer questions. After she voluntarily appeared at the ICE office in Dulles Airport on multiple occasions, she was taken into custody and sent to a regional jail in Virginia. At the airport, Ms. Kenley and her sister explained that she

suffered from high blood pressure, high cholesterol, and a bleeding uterine fibroid that required surgery. She died in detention a few months later. Both Rev. Dantica and Ms. Kenley had family in the United States and had no record of violating any immigration laws. In fact, both had repeatedly demonstrated their respect for our immigration laws, and were neither a danger to society nor a flight risk. Both were clearly too sick to be placed in a system incapable of meeting their medical needs.

Fix: Procedures to Make Seriously Ill Detainees Priority for Alternatives to Detention

The Detainee Basic Medical Care Act of 2008 requires DHS to design procedures ensuring that detainees with serious medical or mental health problems receive priority consideration for release on parole, bond, or into a community-based secure alternative to detention program.

Problem: Excessive Delays in Responding to Requests for Medical Attention

Detainees regularly report to us that they are often forced to wait long periods of time to get a response to request for medical attention. At three of the five facilities audited by the OIG in connection with its December 2006 report, nearly half of the medical files reviewed showed that requests for medical attention were not responded to in the timeframe required by each facility's own policies.[23] At SDCF, more than half of the files reviewed demonstrated response times exceeding three days.[24]

Yusif Osman was a detainee at SDCF who died an avoidable death due to delays in treatment. His tragic story was featured in the recent *Washington Post* series about ICE's failure to provide adequate medical care to people in its custody.[25] Mr. Osman, a national of Ghana, who had previously

[23] OIG Audit Report at 4.

[24] *Id.*

complained to medical staff of chest pain, was found dead while locked in his cell one morning in June 2006. He died of coronary vasculitis, a heart condition that was neither diagnosed nor treated while he was detained, despite his efforts to receive medical attention. On the night of his death, Mr. Osman and his cellmate requested immediate medical attention, and a correctional officer observed Mr. Osman, who was suffering from severe chest pain, kneeling on the floor of his cell. The officer notified medical personnel of the situation, but the nurse on duty told the correctional officer to advise Mr. Osman to submit a written sick call request. By the time Mr. Osman was next observed in his cell, he was completely unresponsive and cool to the touch. More than one hour passed between the time Mr. Osman and his cellmate requested urgent medical attention and the time that a 911 call was made in response to the medical emergency.

Fix: Procedures to Ensure Timely Access to Treatment

The Detainee Basic Medical Care Act of 2008 requires DHS to design procedures ensuring that detainees receive prompt responses to requests for medical or mental health care.

Problem: Off-Site Bureaucrats Make Medical Care Decisions

Right now, professional clinical judgments made by qualified on-site medical personnel can be trumped by Managed Care Coordinators (MCC) within DIHS. These MCCs—who are nurses, not doctors—are able to deny requests for necessary off-site care without physician review, and with no meaningful, independent review of their decisions. Moreover, the policies that guide the decisions of the MCCs are fatally flawed. DIHS primarily provides health care services for emergency care only.[26] Emergency care is defined as "a condition that is threatening to life, limb, hearing, or sight."[27]

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[25] Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

[26] Division of Immigration Health Services, *DIHS Medical Dental Detainee Covered Services Package*, undated, available at http://icchealth.org/ManagedCare/Combined%20Benefit%20Package%202005.doc.

[27] *Id.* at 1.

When a detainee has a medical condition that a physician believes, "if left untreated during the period of [ICE] custody, would cause deterioration of the detainee's health or uncontrolled suffering affecting his/her deportation status," the condition will be assessed and evaluated for care.[28] The introduction of a non-medical consideration such as whether the detainee's "uncontrolled suffering" will affect the government's ability to effectuate deportation is entirely inappropriate. In myriad ways, DIHS's policies and practices are inconsistent with established principles of constitutional law and basic notions of decency. This system is designed to fail, and it does daily.

Fix: Procedures to Ensure Only Qualified Medical Professionals Determine Care

The Detainee Basic Medical Care Act of 2008 requires DHS to design procedures to ensure that treatment decisions are based solely on the expertise of qualified medical professionals.

Problem: Bureaucratic Decisions to Deny Necessary Medical Care Cannot Be Appealed

The treatment authorization process for off-site care results in both unreasonable delays in the provision of medical care, and unjustifiable refusals to provide authorization. In 2005 only the DIHS Medical Director or a person designated by the Medical Director had authority to deny a request for treatment authorization. In the event that the Medical Director chose to deny authorization, the on-site health professional could file an administrative appeal with DIHS and have his concerns heard by an impartial panel of three DIHS physicians with the power to overturn the Medical Director's denial. That appeals system was abolished sometime in 2007. As a result, there is currently no administrative reconsideration or appeals process for authorization denials, and the registered nurses who

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[28] *Id.*

work as MCCs now have the last word in denying authorization for treatment requested by on-site medical professionals. Although there are 33,000 detainees in custody on any given day, the task of evaluating all requests for treatment falls on three regional MCCs.[29] A fourth MCC was once assigned to oversee requests pertaining to detainees requiring hospitalization, but even that task has now been placed on the shoulders of the three regional MCCs.[30]

Francisco Castaneda was one victim of DIHS's deficient benefits package and lack of appeals process. He entered SDCF in March 2006 and immediately complained about increasingly painful lesions on his penis. After being examined by an on-site doctor, he was told he needed to see a specialist for his condition. Many months later, during which time Mr. Castaneda's condition worsened and he began bleeding and discharging from his penis, DIHS approved the request. During his 11-month stay in immigration detention, eight of which were at SDCF, Mr. Castaneda saw multiple specialists who agreed he needed a biopsy to determine whether his condition was cancerous. Medical staff at SDCF, acting in accordance with DIHS policy, repeatedly refused to schedule Mr. Castaneda for a biopsy, stating it was "elective surgery."

The ACLU sent several demand letters to DHS and DIHS on his behalf and finally, in February 2007, Mr. Castaneda's biopsy was scheduled. But before sending him for the biopsy, ICE released Mr. Castaneda—who had by this time developed multiple tumors on and around his penis—from detention. Mr. Castaneda immediately went to the emergency room for a biopsy, at which point he learned that he was suffering from penile cancer. His penis was immediately amputated, and the doctors determined that the cancer had already spread to his lymph nodes. Despite undergoing numerous rounds of aggressive chemotherapy treatment and having his

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[29] Division of Immigration Health Services, Managed Care Coordinators at http://icchealth.org/ManagedCare/ManagedCare.shtm (last visited May 30, 2008).

[30] *See id.*

lymph nodes surgically removed, Mr. Castaneda's cancer continued to spread. He died on February 16, 2008. Throughout his battle he remained a staunch advocate for others like him who were refused necessary medical care while in ICE detention. He testified before the House Subcommittee on Immigration in October 2007, just five months before he died, about the inadequate treatment he received while in ICE custody.

Fix: Development of an Administrative Appeals Process

The Detainee Basic Medical Care Act of 2008 requires DHS to develop an administrative appeals process for people in ICE detention whose treatment requests are denied. It also creates protocols to ensure DIHS provides written explanations for denying treatment.

Problem: Medical Records are not Transferred with Detainees and are Largely Inaccessible

Detainee medical records are critical to ensuring that proper health care is provided throughout detention. DHS's current policy is that when a detainee is transferred between facilities at which DIHS provides medical care, a detainee's medical records are transferred along with the detainee. However, when a detainee is transferred between all other facilities, no medical records are sent. In some cases, all that is sent along with a detainee is a one-page transfer summary listing the prescription medications that the detainee takes. The obvious result of this policy is that detainees with the most complex medical needs often pose a serious problem for the medical personnel of a receiving facility.

This problem is exacerbated by the difficulty that detainees and their advocates have in obtaining medical records from detention facilities. The ICE Detention Standard on Medical Care states that detainees may request their medical records.[31] But it is the ACLU's experience that in many

[31] Immigration and Customs Enforcement, *INS Detention Standard on Medical Care*, Sept. 20, 2000, 9, available at http://www.ice.gov/doclib/partners/dro/opsmanual/medical.pdf.

facilities, detainees who request copies of their medical records may be refused such access, are told that they can get their medical records only upon release from the facility, or have their requests completely ignored. When the ACLU has submitted medical records requests to ICE, these requests are processed as requests submitted under the Freedom of Information Act ("FOIA"). At best, it takes several weeks to get medical records by filing a FOIA request. In one instance, when the ACLU was attempting to get medical records for Francisco Castaneda, who at the time was still in detention and was suffering extraordinary pain and medical neglect regarding his undiagnosed and untreated penile cancer, it took more than 19 weeks to get the records.

Fix: Procedures to Make Medical Records Accessible to Detainees and Appropriate Personnel

The Detainee Basic Medical Care Act of 2008 requires that DHS develop protocols to make medical records more easily available to appropriate personnel and detainees, and expedite the transfer of medical records when a detainees is moved from one facility to another.

Problem: In-Custody Deaths Go Unreported

ICE has no legal obligation to report in-custody deaths. Since the creation of ICE in 2003, at least 83 people have died in immigration custody or shortly after being released from ICE custody, and according to records released to the ACLU by ICE pursuant to a Freedom of Information Act, at least 9 of these deaths were AIDS-related. The *Washington Post* estimates that 30 of the 83 deaths may have resulted from medical neglect.[32]

Fix: Procedures to Ensure Oversight of Deaths in ICE Custody

The Detainee Basic Medical Care Act of 2008 would require DHS to report all in-custody deaths to the Department of Justice Inspector General's Office, the Department of Homeland Security Inspector

[32] Dana Priest and Amy Goldstein, *System of Neglect*, WASHINGTON POST, May 11, 2008.

General's Office, and to Congress. This reporting and accountability requirement is necessary to ensure that Congress, the public, and detainees' family members are no longer kept in the dark about deaths of detainees.

V. Conclusion

The ACLU has found that medical care in immigration detention is grossly inadequate and insufficiently regulated by any government body. Increased oversight and procedures to ensure people in ICE detention receive constitutional and humane care are urgently needed. Too many people in ICE detention have been forced to suffer and even die unnecessarily. Such degrading and deplorable treatment contradicts American values. It is imperative that Congress take action to protect the rights and human dignity of people with serious medical or mental health conditions in ICE detention. The Basic Medical Care Act of 2008 will bring us closer to reaching that goal.

June 4, 2008

Statement on the Need for Independent Monitoring of Medical Care in ICE Detention

I am author of *American Gulag: Inside US Immigration Prisons* (University of California Press, 2004), and I teach English at Hunter College in New York.

ICE practices must be subject to independent monitoring and oversight.

ICE brags about its detention standards, but ICE has worked hard -- most recently during negotiations on last year's immigration package -- to make sure that its detention standards do not become legally enforceable.

Monitoring of ICE detention conditions, including medical care of detainees, is at the discretion of ICE itself.

For example, groups contracted to monitor compliance with standards are paid by ICE itself. ICE allows groups such as the ABA and UNHCR into its detention centers and jails on the condition that the groups do not release findings to the media. And ICE violates its own standards regarding media access.

Office of Inspector General (OIG) reports always come after the fact. Unfortunately, the OIG, in recent reports, simply suggests that ICE police itself.

The way to begin protecting detainees in the ICE system is to create a statutory-based ombudsman's office or independent oversight body outside the Department of Homeland Security.

This body must have subpoena power as well as authorization to make unannounced inspections of all facilities holding ICE detainees.

This office would have two straightforward mandates, both irrelevant to one's position on immigration itself: Ensure that everyone in custody of the immigration agency is being lawfully detained, and that all incarcerated people are treated humanely.

Please see attached article from *Bender's Immigration Bulletin* for further details.
http://tinyurl.com/2t6gbg

More on the forced sedation of detainees (cases, background, and examples of Immigration violating its own stated policies) can be found in *American Gulag* at pp. 70-84 and 333-36.

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Why ICE Cannot Police Itself: Monitoring Immigration Detention

By Mark Dow

In a new report documenting the mistreatment of immigrants imprisoned by U.S. Immigration and Customs Enforcement (ICE), the Department of Homeland Security's Office of Inspector General (OIG) has helped ensure that, for now, the mistreatment will continue.

The OIG report tells of a detained woman's rape by a guard (the alleged perpetrator lost his job but wasn't prosecuted), arbitrary disciplinary actions, interference with detainees' ability to contact lawyers and family members, dangerously undercooked food, improper medical care, and neglect of suicidal prisoners. All of these, and more, have been documented extensively for more than two decades now, since long before "detainee abuse" became a familiar phrase, by a gamut of reporters, human rights groups, and courageous detainees who have signed letter after letter, risking retaliation, to ICE, the OIG, members of Congress, and the media.

Retaliation against detainees as well as employee whistleblowers is commonplace in ICE. The OIG details one instance of the "appearance of retaliation" by Hudson County, New Jersey, guards against a detainee for speaking out - and demonstrates the disconnect between even well-intentioned bureaucrats and the remote lock-ups where the only consistent standard is arbitrary power. The report notes that "although confidential, the meeting with OIG staff was known to [jail] officials." It is bizarre that the auditors would be surprised by this breach since two sentences earlier they report that jail staff transported the detainee "to the ICE field office building for an interview with our audit team." Note that the team auditing ICE is using ICE offices.

Then the OIG suggests that ICE figure out why its own inspections (supposedly) didn't turn up the violations which OIG auditors found. ICE's shameless response is that it failed to find these violations because its own self-monitoring is based on "a reasonable assessment within a reasonable period of time." In other words, the OIG spent an unreasonably long time investigating and therefore found more problems.

How have these problems remained under the radar for so long? The innocuous title of the new OIG report - *Treatment of Immigration Detainees Housed in Immigration and Customs Enforcement Facilities* - provides a couple of clues. The "detainees" are prisoners. The "facilities" are prisons and jails scattered through the country, most of which hold the immigrant detainees alongside sentenced inmates. As for "housed," an immigration official in Miami admitted long ago that his agency was "warehousing" these people. They have no release dates and are held for days, weeks, months, years, even decades, with no criminal charges against them. They are in "administrative custody," and there are almost 30,000 of them.

So what does the OIG recommend? That the agency responsible for the mistreatment of its prisoners, and whose own inspections are deficient, "ensure that periodic oversight and inspection procedures are in place to address compliance with the Detention Standards." The report neglects to mention that ICE has refused to promulgate its detention standards as regulations because they would then be, at least theoretically, legally enforceable. *The Washington Post* has suggested ("Locked in Squalor," January 24, 2007) that "if ICE's claims [that it is concerned with detention conditions] are true, it should have no argument with making regulations of its own guidelines." This is a useful rhetorical move, but while ICE lawyers and press officers craft a response, reporters and legislators should be aware that, for years, the immigration agency successfully resisted putting even unenforceable detention standards in writing. At the same time, top government litigators have strategized about exploiting the victims' status as noncitizens to justify their mistreatment. Here is Paul Kovac, a Justice Department attorney who was detailed for a time to Senator Orrin Hatch's office: "An alien's status in this country may also dictate the degree of constitutional protections he or she may be afforded. Perhaps some of these same constitutional principles can be applied to aliens challenging their treatment while in INS detention." ("Force Feeding of Detained Aliens," Department of Justice, *Immigration Litigation Bulletin* 5.1, 1/31/01).

In a response appended to the OIG report, ICE chief Julie Myers claims that "ICE has . . . historically demonstrated that, when a facility fails to meet the intent of the [National Detention Standards], the relationship with the deficient facility is terminated." Despite my repeated requests, ICE public affairs has failed to say which facilities these might be. In fact, ICE has "historically demonstrated" that it will refuse to stop even the most brutal mistreatment in its "facilities" until outside pressure becomes too strong: examples include the use of attack dogs in New Jersey and of "shock shields" in Florida.

The bottom line is this: "auditing" without truly independent enforcement is meaningless.

In 2004, the General Accounting Office reported that ICE was detaining hundreds of persons who should have been released under the Supreme Court's ruling in *Zadvydas v. Davis* three years earlier. But the GAO simply recommended that ICE itself remedy the problem. In other words, someone who is being illegally incarcerated by ICE has no options other than trying - without the right to court-appointed counsel - to file a habeas petition in district court to demand justice from an agency already violating the Supreme Court ruling on the matter. An OIG audit on this same problem is reportedly nearing completion. *Should this audit reveal that ICE is still detaining people illegally, there will still be nothing for those prisoners to do about it.*

It isn't politically popular to speak up for alien inmates, but Congress has a responsibility to establish independent oversight of the ICE detention system. Congress should hold hearings on ICE detention - with meaningful follow-up. Create a statutory-based ombudsman's office or independent oversight body outside the Department of Homeland Security. It must have subpoena power as well as authorization to make unannounced inspections of all facilities holding ICE detainees. This office would have

two straightforward mandates, both irrelevant to one's position on immigration itself: Ensure that everyone in custody of the immigration agency is being lawfully detained, and that all incarcerated people are treated humanely.

Eventually, the very nature of our immigration detention system must be re-examined. We take it as a given that a visa violator, or an asylum seeker, or a thirty-year lawful resident who has paid taxes but committed a non-violent misdemeanor decades ago, should be strip-searched, dressed in a prison jumpsuit, and denied contact with her children. Immigration officials and correctional officers explain at length in my book that mistreatment is the inevitable result of imprisoning people who are only subject to administrative "detention."

Humane alternatives are available and uncomplicated. In the mean time, the situation of the 200,000 vulnerable people who pass through the immigration prison system every year remains an urgent one.

Mark Dow is author of *American Gulag: Inside US Immigration Prisons*. He teaches English at Hunter College in New York.

HUMAN RIGHTS WATCH

HIV/AIDS Services for Immigrants Detained by the United States

Submitted by
Human Rights Watch
HIV/AIDS and Human Rights Program
June 4, 2008

Human Rights Watch respectfully submits this testimony to the House Judiciary Committee Subcommittee on Immigration, Citizenship, Refugees, Border Security and International Law as it examines the issue of medical care for immigration detainees. Human Rights Watch, an independent non-governmental organization founded in 1978, has documented human rights abuses around the world. We are the largest human rights organization in the United States, and regularly report on US detention and criminal justice issues including prison conditions, prison medical care, and conditions of confinement for immigration detainees.[1] We monitor human rights violations that fuel the HIV epidemic and impede access to life-saving treatment, both in the United States and around the world.[2]

In December 2007 Human Rights Watch released "Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States," a report documenting the substandard medical care and services for immigration

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[1] *See*, e.g. Human Rights Watch and ACLU,, *Custody and Control: Conditions of Confinement in New York's Juvenile Prisons for Girls* (New York: September 2006); Human Rights Watch, *So Long As They Die: Lethal Injections in the United States* (New York: April 2006); Human Rights Watch, *Locked Away: Immigration Detainees in Jails in the United States* (New York: September 1998).

[2] See, e.g., Human Rights Watch, *Life Doesn't Wait: Romania's Failure to Protect and Support Children and Youth Living with HIV* (New York: August 2006); Human Rights Watch, *Injecting Reason: Human Rights and HIV Prevention for Injection Drug Users* (New York: September 2003).

detainees with HIV/AIDS.[3] Copies of this and other Human Rights Watch reports are available at http://hrw.org/reports/2007/us1207/. Key findings of "Chronic Indifference" are summarized below.

The US Provides Substandard Care and Services to Detainees with HIV/AIDS

There are more than 30,000 individuals in immigration detention in the United States, held in hundreds of prisons, jails, and immigration centers throughout the United States. The US Department of Homeland Security (DHS), which is responsible for ensuring that these individuals receive necessary medical care, does not know how many of these individuals have HIV or AIDS, how many need treatment, or how many are receiving the care they need. DHS policies fail to meet national or international standards for appropriate HIV/AIDS care and treatment, and the agency fails to enforce its own minimal standards. As a result, HIV-positive immigrants in detention risk serious illness, needless suffering, and premature death.

In 2007, Human Rights Watch conducted interviews with current and former detainees, attorneys and advocates working on immigration detention, DHS officials, and wardens at local detention centers. An HIV clinician also conducted an independent medical review of treatment provided to specific detainees. Our research revealed a failure by DHS to ensure basic standards of care to HIV-positive immigrants in its custody.

Antiretroviral medications are not delivered consistently

Antiretroviral medications are critical to sustaining the lives and health of people living with HIV/AIDS. But for antiretroviral therapy to be effective, it is critical that patients adhere fully to the medication regimen. Human Rights Watch found that detention facilities frequently delivered partial and incomplete antiretroviral medications to HIV-positive detainees and that delivery of these life-saving medications was often delayed and interrupted. Such inconsistent treatment creates a serious health risk for

[3] Human Rights Watch, *Chronic Indifference: HIV/AIDS Services for Immigrants Detained by the United States* (New York December 2007.)

individual detainees as well as for the larger community. It endangers an HIV-positive detainee's health by creating a risk of drug resistance by reducing the number of medications that can be used to treat his or her disease. Inconsistent treatment also leads to the development of drug resistant strains of the virus which can then be transmitted to others, creating a public health impact in the community.

Peter R., a 43-year-old man from Jamaica was detained at Hampton Roads Regional Jail in Portsmouth, Virginia. "There seemed to be no system for giving us the AIDS drugs," said Peter. Peter kept a diary in July 2007 to record his medication delivery. This diary shows an erratic delivery of HIV/AIDS medication in which he received a correct dosage (3 pills in the morning, 3 pills in the evening) only 65 percent of the time.

Inconsistent HIV care can be devastating to a detainee's health. Charles B. was held in detention for four years and eight months, during which time medical staff provided incomplete prescriptions and antiretroviral drugs to which he had demonstrated resistance. As a result, Charles B. developed resistance to thirteen primary HIV/AIDS medications, severely restricting doctors' ability to treat his condition, even in the United States, and now suffers from disabling neurological problems.

Fundamental clinical monitoring and testing is not conducted

Tests that are fundamental to effective treatment of HIV/AIDS, including tests for CD4+ T cells, viral load and resistance, were conducted sporadically or not at all.

"I have no idea what my T cells are or how I am doing with this virus," said Diane P., a 41-year-old woman from Trinidad detained at Monmouth County Correctional Center in New Jersey. Independent medical review of Diane's medical records showed that four months after her arrival at the jail she had not received complete lab work necessary to effectively treat her condition. Test results indicated that her viral load was not as suppressed as it should have been after months on antiretroviral therapy. Her medication regimen should therefore have been reevaluated and resistance testing conducted, but this was not done.

Life-threatening infections are not prevented or treated.

HIV attacks the body's immune system, leaving patients vulnerable to serious infections such as meningitis or pneumocystis pneumonia (often called "opportunistic infections"). Independent medical review showed that James L., a 44- year-old musician and drum instructor from Haiti, and Anna F., a 51- year-old detainee born in Germany, had CD4 counts so low as to require prophylactic medication to prevent opportunistic infections, yet none was prescribed.

Opportunistic infections can be fatal. Victoria Arellano, a 23-year-old transgendered detainee, vomited blood and became too weak to sit up in her bunk as her condition became critical. According to witnesses, detention center authorities – including medical staff – ignored her symptoms and suffering, and Ms. Arellano died of meningitis after 8 weeks in immigration detention.

Continuity of care and necessary specialty care is not ensured.

National correctional standards for HIV care require emphasize the importance of continuity of care and access to specialty medical care for this complex disease. DHS frequently transfers detainees within the immigration detention system without ensuring continuity of care for HIV-positive immigrants.

In a letter to Human Rights Watch, Samuel L. described his inability to keep an appointment with an HIV specialist:

"I have been here for six months now and I haven't seen a specialist on chronic disease. When I was in Arizona, the health care provider scheduled me to see a specialist...But I wasn't able to go because I was transferred back to California."

Jean P., 35, who suffers from high blood pressure as well as HIV and is blind in one eye from CMV retinitis (an opportunistic infection found in advanced AIDS patients) was transferred four times during a six-month

period in 2007. According to his attorney, whose representation of Jean was repeatedly interrupted, the government failed to provide any explanation for these transfers. Independent medical review of Jean's chart showed no eye exam during two years in detention and other examples of his disrupted care.

Confidentiality of medical care is not ensured, exposing detainees to discrimination and harassment.

Detainees described crowded, hectic pill distribution systems and staff insensitivity that failed to protect the confidentiality of prisoners with HIV/AIDS. US law and international standards require that information about HIV status be protected against unauthorized disclosure. The failure to ensure confidentiality about HIV-related care threatens these important protections as well as other fundamental rights. Still stigmatized, HIV-positive, gay and transgender detainees face abuse and harassment from staff and other prisoners. In the absence of any ICE policies designed to prevent or punish discrimination, they have neither protection nor recourse from such treatment.

Antonio O., 33, is a gay man living with HIV who was detained at the San Pedro Service Processing Center in San Pedro, California, Antonio told Human Rights Watch, "The guards yell at me, make fun of me, they look at me with disgust."

> *"Are you the one that's HIV positive?"* – question asked by ICE officer to Anna F. in front of other detainees at the Varick Street detention facility in New York City.

Policies and Procedures for Detainees with HIV/ AIDS are Inadequate.

Immigration detainees receive sub-standard HIV care and services because DHS policies and procedures fail to ensure that adequate care is provided.

DHS fails to collect basic information about detainees with HIV/ AIDS

DHS fails to collect basic information concerning HIV/AIDS cases in the hundreds of detention facilities contracting with Immigration and Customs Enforcement (ICE) to incarcerate immigrants. Human Rights Watch requested, through the Freedom of Information Act, data as fundamental as the number of immigration detainees with HIV/AIDS—only to discover that this information is "not tracked." Failure to collect this vital information, as well as information about the treatment and services provided to detainees with HIV/AIDS, prevents DHS from improving its programs to meet the needs of this vulnerable population.

DHS guidance fails to meet national or international standards for HIV care.

The DHS policies and procedures for HIV/AIDS should describe appropriate treatment protocols for people living with HIV/AIDS to be followed in its own facilities as well as those it utilizes to provide care. DHS policies and procedures, however, are conflicting, confusing and incomplete, and fail to conform to national and international guidelines for HIV/AIDS care in correctional settings. Further, DHS has failed to adopt their internal detention standards as formal administrative regulations, making the standards largely unenforceable. Although ICE "outsources" much of its immigration detention to local jails and facilities across the United States, its responsibility for adequate standards of care may not be delegated or evaded by contracting with third parties.

DHS fails to adequately monitor the quality of health care provided to detainees with HIV/ AIDS

The inspection system for most facilities contracting with ICE fails to provide the oversight necessary to identify and resolve the deficiencies in medical care – a problem that the Government Accountability Office (GAO) has documented. A 2007 GAO report found serious flaws in the quality of ICE's inspections and in its mechanisms for ensuring that detainee complaints, including those pertaining to medical care, are properly monitored and resolved.[4]

[4] Government Accountability Office Report GAO-07-875 (GAO Report): Alien Detention Standards, July 2007.

DHS Documents Confirm Substandard Care for Detainees.

Documents recently obtained by the Washington Post support Human Rights Watch's findings of substandard care for HIV-positive detainees.[5] An internal ICE review of the death of Victoria Arellano, the 23-year-old transgendered detainee with AIDS who died in federal custody states in "off the record observations and recommendations" that:

> *The clinical staff at all level fails to recognize early signs and symptoms of meningitis. In an advanced AIDS patient with CD4 counts of less than 100 and without proper prophylaxic treatment a severe headache associated with nausea and vomiting must raise the suspicion of a CNS toxoplasmosis or a Cryptococcal meningoencephalitis. Pt. was evaluated multiple times and an effort to rule out those infections was not even mentioned.*[6]

The ICE review also calls into question the policy of denying lab work to all detainees until they had been held for more than 30 days. As the reviewer acknowledges, such a policy violates medical protocol and endangers the lives of patients with HIV/AIDS, noting specifically:

> *...that practice is particularly dangerous with many chronic care cases and specially HIV/AIDS patients. Labs for AIDS patients (CD4 count and HIV RNA by PCR) must be performed ASAP to know their immune status and were you are standing in reference to disease control and meds. In this particular case it took them 22 days to perform the lab work.*[7]

Another document obtained by the Washington Post demonstrates that ICE headquarters repeatedly denied life-saving medications to detainees with HIV/AIDS. An accounting record entitled "TAR Cost Savings Based on

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[5] See Dana Priest and Amy Goldstein, "System of Neglect," *The Washington Post*, May 11, 2008.

[6] Division of Immigration Health Services Case Summary of the death of V. Arellano, undated, para. 1, cited and included in online materials for "System of Neglect," *supra*, at http://media.washingtonpost.com/wp-srv/nation/specials/immigration/documents/day1_arellano.pdf, accessed May 27, 2008.

[7] Ibid.

Denials" shows that during the period October 2005-September 2006, 17 requests from medical staff at detention facilities for HIV/AIDS medications were denied. Denial of these TARs (Treatment Authorization Requests) from medical staff saved ICE a total of $129,713.62.[8]

For copies of these documents, please see Appendices.

Conclusion

HIV-positive detainees are truly an at-risk population dispersed throughout the hundreds of detention centers, private prisons and local jails used by the Department of Homeland Security to hold immigrants. Vulnerable to discrimination and harassment and often denied fundamental treatment and services, immigrant detainees with HIV/AIDS continue to suffer, and in some cases, die, in detention. DHS must act now to bring its procedures and policies into conformity with national and international standards. Specifically, Human Rights Watch strongly supports HB 5950, the Detainee Basic Medical Care Act of 2008 that establishes a threshold for adequate medical care for immigration detainees. HRW further urges the following recommendations to be implemented without delay:

Recommendations

To the US Department of Homeland Security

- Increase the number and quality of inspections of all facilities contracting with DHS to detain immigrants
- Revise and upgrade the medical care detention standard to conform to national and international standards for HIV care
- Convert the DHS internal detention standards to enforceable administrative regulations
- Adopt a non-discrimination policy to prevent and punish abuse or harassment of HIV-positive, gay and transgender detainees

[8] "TAR Cost Savings Based on Denials 10/1/2005-9/30/2006," undated, cited and included in online materials for "System of Neglect," *supra*, at http://media.washingtonpost.com/wp-srv/nation/specials/immigration/documents/day2_tardocs.pdf, accessed May 27, 2008.

- Promote alternatives to detention for detainees with serious chronic medical conditions

To the Division of Immigration Health Services

- Collect vital information about the number of detainees with HIV/AIDS, the care provided to them and the services available. Use this information to develop programs and policies to address the needs of this population
- Develop a program for voluntary testing, counseling and education for HIV

To Immigration and Customs Enforcement

- Require compliance with the Medical Care Detention standards (as revised above) as an express condition of all contracts with private, county or local facilities
- Improve the current system for tracking complaints from detainees relating to inadequate medical care
- Ensure that all detainees receive medical care free of charge

To the US Congress

- Ensure that all immigration detainees in federal custody are subject to standards for medical care that comply with national and international standards
- Establish a monitoring body independent of the Department of Homeland Security with the responsibility and expertise to ensure that all facilities housing immigration detainees comply with national and international health care standards

1115 North Imperial Avenue
El Centro, CA 92243
(760) 336-4644

To: Timothy Shack, M.D.
Medical Director
Division of Immigration Health Services

From: CDR Carlos Duchesne, M.D.
Clinical Director
El Centro Medical Referral Center

Re: Detainee Victor Alfonso Arellano

This is a case summary of the death of detainee Victor Alfonso Arellano # 077991267.

Division of Immigration Health Services
El Centro ICE Medical Facility
1115 North Imperial Avenue
El Centro, CA 92243
(760) 336-4644

Off the record observations and recommendations.

1. The clinical staff at all levels fails to recognize early signs and symptoms of meningitis. In an advanced AIDS patient with CD4 counts of less than 100 and without proper prophylaxis treatment a severe headache associated with nausea and vomiting must raise the suspicion of a CNS toxoplasmosis or a Cryptococcal meningoencephalitis. Pt was evaluated multiple times and an effort to rule out those infections was not even mentioned.
2. It was brought to my attention by the San Pedro HSA and some staff members that the Clinical Director mandated all providers to hold lab work to all new detainees. They are only allowed to order labs if the detainee is in the institution for more than 30 days. I am sure that there must be a reason why this was mandated but that practice is particularly dangerous with many chronic care cases and specially HIV/AIDS patients. Labs for AIDS patients (CD4 count and HIV RNA by PCR) must be performed ASAP to know their immune status and were you are standing in reference to disease control and meds. In this particular case it took them 22 days to perform the lab work.

3. Failure to address alternative prophylaxis medications to avoid opportunistic infections. There was no real evidence of allergic reaction to bactrim, azythromycin or dapsone as the patient claimed. Allergy testing and possible desensitization was very important in a case like this. Medications like fluconazole and itraconazole could have prevented infection with Cryptococcus. Use of atovaquon or pentamidine is useful for PCP prevention. There was no documentation (provided) that prophylaxis was necessary.
4. Inappropriate use of Cipro with incorrect dosing. Cipro was ordered by the physician for the treatment of URI. The dose was ordered as 500 mg po stat then 250 mg daily for the next 4 days. Resistance to Cipro by many organisms is well documented. In an immuno-supressed AIDS patient this antibiotic for treatment of URI is completely useless.

TAR Cost Savings based on Denials

10/1/2005 - 9/30/2006

Diagnosis	TARs	Cost Savings
011.90 - UNSPEC PULMONARY TUBERCULOSIS CONF UNSPEC	3	$26,458.76
034.0 - STREPTOCOCCAL SORE THROAT	3	$10,631.31
042 - HUMAN IMMUNODEFICIENCY VIRUS [HIV]	17	129,713.62
052.9 - VARICELLA WITHOUT MENTION COMP	3	$12,405.35
245.9 - UNSPECIFIED THYROIDITIS	2	$6,887.16
250.00 - DIABETE S UNCOMPL TYPE II NO UNCNTRL	2	$4,751.34
276.5 - VOLUME DEPLETION	1	$3,266.96
276.51 - DEHYDRATION	14	$70,192.36
292.0 - DRUG WITHDRAWAL SYNDROME	4	$13,868.21
295.3 - SCHIZOPHRENIA-PARANOID TYPE	1	$7,402.37
295.30 - PARANOID SCHIZOPHRENIA UNSPEC COND	1	$8,089.36
296.80 - MANIC-DEPRESSIVE PSYCHOSIS UNSPEC	4	$18,145.36
296.90 - UNSPECIFIED AFFECTIVE PSYCHOSIS	1	$6,402.16
298.9 - UNSPECIFIED PSYCHOSIS	2	$11,668.60
309.81 - PROLONG POSTTRAUMAT STRESS DISORDER	1	$5,920.85
309.9 - UNSPECIFIED ADJUSTMENT REACTION	1	$ 882.00
311 - DEPRESSIVE DISORDER NOT ELSEWHERE CLASSIFIED	9	$43,158.57
401.9 - UNSPECIFIED ESSENTIAL HYPERTENSION	17	$68,043.52
413.9 - OTH & UNS ANGINA PECTORIS	1	$3,140.36
414.9 - UNSPEC CHRONIC ISCHEMIC HRT DISEASE	1	$4,187.89
427.89 - OTH SPEC CARDIAC DYSRHYTHMIAS	1	$3,222.17
455.2 - INTERNAL HEMORRHOIDS WITH OTH COMPLICATION	2	$11,487.21
462 - ACUTE PHARYNGITIS	27	$88,723.89
465.9 - ACUTE UPPER RESPIRATORY INFECTIONS OF UNS SITE	16	$64,111.20
466.0 - ACUTE BRONCHITIS	2	$9,898.72
475 - PERITONSILLAR ABSCESS	1	$1,893.70
481 - PNEUMOCOCCAL PNEUMONIA	1	$ 400.51
486 - PNEUMONIA, ORGANISM UNSPECIFIED	1	$6,606.27
491.21 - OBSTRUCTIVE CHRONIC BRONCHITIS WITH EXACERBATION	1	$6,481.00
493.90 - UNS ASTHMA WO MO STATUS ASTHMATICUS	3	$10,842.93
493.91 - UNSPEC ASTHMA W/STATUS ASTHMATICUS	1	$4,979.41
518.89 - OTH DISEASES OF LUNG-NEC	1	$4,765.21
530.81 - ESOPHAGEAL REFLUX	6	$20,613.36
558.9 - OTH&UNSPEC NONINFECTIOUS GASTROENTERITIS&COLITIS	1	$3,059.69
564.00 - UNSPECIFIED CONSTIPATION	2	$6,213.66
571.2 - ALCOHOLIC CIRRHOSIS OF LIVER	2	$23,080.22
573.3 - UNSPECIFIED HEPATITIS	2	$8,986.81
575.0 - ACUTE CHOLECYSTITIS	2	$14,845.16
578.0 - HEMATEMESIS	1	$3,008.71
578.1 - BLOOD IN STOOL	2	$9,545.50
578.9 - UNSPEC HEMORRHAGE GI TRACT	2	$8,063.04
584.9 - UNSPECIFIED ACUTE RENAL FAILURE	1	$6,341.32
585 - CHRONIC RENAL FAILURE	1	$2,013.35
592.0 - CALCULUS OF KIDNEY	2	$6,712.56

TAR Cost Savings based on Denials

10/1/2005 - 9/30/2006

Diagnosis	TARs	Cost Savings
599.0 - UTI SITE NOT SPECIFIED	3	$16,088.23
599.7 - HEMATURIA	17	$37,715.18
620.2 - OTHER AND UNSPECIFIED OVARIAN CYST	2	$8,999.32
625.9 - UNSPEC SYMPTOM ASSOC W/FEMALE GENITAL ORGANS	1	$4,883.46
626.2 - EXCESSIVE OR FREQUENT MENSTRUATION	1	$5,050.35
632 - MISSED ABORTION	4	$11,974.84
682.3 - CELLULITIS&ABSC UPPER ARM&FOREARM	3	$13,104.66
682.4 - CELLULITIS&ABSC HAND NO FNGR&THUMB	1	$2,893.09
682.7 - CELLULITIS&ABSCESS FOOT EXCEPT TOES	2	$11,646.56
729.81 - SWELLING OF LIMB	1	$4,190.48
780.09 - OTHER ALTERATION OF CONSCIOUSNESS	1	$6,971.68
780.2 - SYNCOPE AND COLLAPSE	5	$22,216.90
780.39 - OTHER CONVULSIONS	4	$15,888.97
784.7 - EPISTAXIS	1	$2,462.90
786.3 - HEMOPTYSIS	5	$23,075.48
786.50 - UNSPECIFIED CHEST PAIN	27	$91,926.65
786.59 - OTHER CHEST PAIN	4	$13,222.82
786.6 - SWELLING, MASS, OR LUMP IN CHEST	3	$28,773.12
787.01 - NAUSEA WITH VOMITING	1	$2,099.66
789.03 - ABDOMINAL PAIN RIGHT LOWER QUADRANT	3	$7,528.98
789.06 - ABDOMINAL PAIN, EPIGASTRIC	2	$8,196.39
789.09 - ABDOMINAL PAIN OTHER SPECIFIED SITE	6	$39,704.37
795.5 - NONSPEC REACT TUBERCULIN SKN TEST W/O ACTV TB	3	$16,495.92
824.4 - CLOSED BIMALLEOLAR FRACTURE	1	$6,592.57
824.8 - UNSPECIFIED CLOSED FRACTURE ANKLE	3	$4,275.00
845.09 - OTHER ANKLE SPRAIN AND STRAIN	1	$5,121.75
847.0 - NECK SPRAIN AND STRAIN	1	$1,869.81
850.0 - CONCUSSION WITH NO LOC	1	$2,918.39
924.11 - CONTUSION OF KNEE	3	$8,710.83
959.01 - HEAD INJURY, UNSPECIFIED	13	$44,601.70
959.7 - INJURY OTHER&UNSPECIFIED KNEE LEG ANKLE&FOOT	6	$23,369.04
992.3 - HEAT EXHAUSTION, ANHYDROTIC	1	$2,034.84
992.5 - HEAT EXHAUSTION, UNSPECIFIED	3	$8,785.49
994.1 - DROWNING AND NONFATAL SUBMERSION	1	$1,991.82
V30.00 - SINGLE LIVEBORN HOSPITAL W/O C-SECTION	1	$1,004.35
V71.2 - OBSERVATION FOR SUSPECTED TUBERCULOSIS	25	$85,389.83
TOTAL SAVINGS:	**329**	**$1,372,887.09**

Letter Signed by Faith Organizations in Support of H.R. 5950 and S. 3005, the Detainee Basic Medical Care Act of 2008

June 3, 2008

Honorable Members of Congress
United States Senate
United States House of Representatives
Washington, D.C. 20515

Dear Member of Congress,

We, the undersigned faith-based leaders and organizations, join to express our support for H.R. 5950, the Detainee Basic Medical Care Act of 2008, sponsored by Representative Lofgren (D-CA), and its Senate companion bill, S. 3005, sponsored by Senator Menendez (D-NJ). These bills would ensure meaningful, minimum standards of medical and mental health care for individuals held in immigration detention. These standards are necessary because the current medical standards of Immigration and Customs Enforcement (ICE), an agency of the Department of Homeland Security (DHS), are not sufficient to protect people in their care. Moreover, current standards are not codified and thus are not enforceable.

Last month, the *New York Times*, the *Washington Post* and *60 Minutes* published reports documenting grossly inadequate medical care and treatment provided to individuals in the federal immigration detention system. Drawing upon medical records, death reports, and other internal memoranda, these investigative reports revealed a system that is poorly managed and understaffed leading to consistently substandard care. The Washington Post reported that 83 deaths had occurred during the five year period from 2003 to 2008. These news reports are corroborated by a 2006 audit from the DHS Office of the Inspector General (OIG)[1] and a 2007 report from the Government Accountability Office (GAO)[2] which found instances of non-compliance with ICE health care standards and that officials at detention facilities reported difficulties in obtaining approval for outside medical and mental health care for detainees.

The faith community is concerned about the government's increasing use of immigration detention and its harmful impact upon children, families and our communities. Many of our organizations regularly perform ministry, conduct vigils and provide legal and social services to immigrants in detention and recognize the need for these proposed reforms. Through our

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[1] Department of Homeland Security, Office of Inspector General, *Treatment of Immigration Detainees Housed at Immigration and Customs Enforcement Facilities*, OIG-07-01 (December 2006), *available at* http://www.dhs.gov/xoig/assets/mgmtrpts/OIG_07-01_Dec06.pdf.

[2] U.S. Government Accountability Office, *Alien Detention Standards: Telephone Access Problems Were Pervasive at Detention Facilities; Other Deficiencies Did Not Show a Pattern of Noncompliance*, GAO-07-875

ministry, members of our congregations, temples, and other places of worship have witnessed or received first-hand accounts of the hardship individuals endure while in immigration detention. Many have also heard from detainees that they are unable to obtain medical treatment in a timely manner and that when they do get attention the staff who provide medical care are unqualified or inadequately trained. These specific accounts are consistent with the in-depth reports referenced above. Taken together they provide powerful evidence that the system of medical care for individuals in immigration detention is fundamentally flawed and in need of immediate reform.

Our diverse faith backgrounds teach us that every human being must be treated with dignity and respect. We applaud Representative Lofgren and Senator Menendez for introducing this important measure to ensure that our country respects the basic human rights of everyone in the country, including vulnerable individuals in detention who must rely on the medical and mental health care the government provides them. We urge you to support H.R. 5950 and S. 3005 to restore decency and fair treatment in our immigration detention system.

Respectfully,

American Friends Service Committee

American Jewish Committee

Casa de Esperanza

Church World Service, Immigration and Refugee Program

The Episcopal Church

Friends Committee on National Legislation

Hebrew Immigrant Aid Society

Hindu American Foundation

Hispanic Coalition for Comprehensive Immigration Reform

Irish Apostolate USA

Jewish Council for Public Affairs

Lutheran Immigration and Refugee Service

Mennonite Central Committee U.S. Washington Office

National Advocacy Center of the Sisters of the Good Shepherd

National Hispanic Christian Leadership Conference

Sikh Council on Religion and Education

Sisters of Mercy of the Americas

Standing For Truth Foundation

Union for Reform Judaism

Unitarian Universalist Association of Congregations

United Church of Christ, Justice and Witness Ministries

United Methodist Church, General Board of Church and Society

World Relief

SUBMISSIONS FROM IMMIGRATION AND CUSTOMS ENFORCEMENT (ICE), U.S. DEPARTMENT OF HOMELAND SECURITY

Office of the Assistant Secretary
U.S. Department of Homeland Security
425 I Street, NW
Washington, DC 20536

U.S. Immigration and Customs Enforcement

JUL 28 2008

The Honorable Zoe Lofgren
Chairwoman
Subcommittee on Immigration, Citizenship, Refugees,
Border Security, and International Law
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Chairwoman Lofgren:

I am writing to provide an update to my June 17, 2008, response to your May 15, letter to Secretary Chertoff, co-signed by Chairman John Conyers about the recent reports on the medical care of detainees in U.S. Immigration and Customs Enforcement (ICE) custody.

As promised, I am providing the information you requested in questions 8–12 regarding the mortality rates at ICE detention facilities. We continue to identify and collect materials related to questions 1–6 and I will provide responsive material to the Committee within 30 days.

The "Fact Sheet" entitled "Mortality Rates at ICE Detention Facilities" that was previously sent to Congress included crude mortality rates based on the number of admissions per year to ICE detention facilities. We have now recalculated the crude mortality rates per 100,000 based on the average daily population for the particular year. These rates are reported below in the chart "ICE Average Daily Population and Mortality Rate of Detainees in Custody." Please note that this analysis does not take the following factors into account: age of detainees at death, length of detention, causes of death, and other co-variates that could be used to standardize these rates to other system's rates. However, the crude mortality rate per 100,000 detainees, based on average daily population, is being used to represent the number of detainee deaths per full year of detention.

While ICE is not required to report detainee deaths to the Department of Justice's Bureau of Justice Statistics (BJS) Death in Custody Reporting Program, ICE has begun to voluntarily report detainee deaths to ensure transparency. Currently, BJS publishes special reports on prison and jail death rates. In the future, BJS will also report ICE detainee death rates. BJS uses average daily population in its denominator to calculate death rates for local jails. The average daily population is the average (or mean) number of detainees in custody per day, per year.

ICE's Office of Detention and Removal Operations (DRO) does not yet have a reliable electronic system to capture detainee morbidity data. Therefore, any of the questions asking to calculate DRO detainee morbidity rates and standardized DRO detainee death rates based on morbidity cannot be answered at this time.

The chart below shows both the mortality rate of detainees in custody, and the average daily population is the average number of detainees in custody per day, per year.

ICE Average Daily Population and Mortality Rate of Detainees in Custody

Fiscal Year	Average Daily Population	Deaths	Death Rate per 100,000 Detainees per Year of Detention
2004	21,928	25	114.0
2005	19,718	16	81.1
2006	22,975	17	74.0
2007	30,295	11	36.3

The chart below shows the mortality rates of detainees in ICE custody, by length of time in custody. As previously indicated, the morbidity rates cannot be calculated. Mortality is based on the number of detainees released during the period in custody indicated in the chart.

Mortality Rate adjusted for Length of Time in ICE Custody
Date Range: October 1, 2003 to May 11, 2008

Time in Custody (days)	Releases	Deaths	Death Rate per 100,000
0 - 60	958,688	33	3.4
61 - 120	104,701	12	11.5
121 - 180	27,657	7	25.3
181 - 240	12,591	5	39.7
241 - 300	6,733	0	-
301 - 360	4,102	3	73.1
361 - 420	3,245	3	92.4
421 - 480	1,872	0	-
481 - 540	1,347	1	74.2
541 - 600	870	0	-
601 - 660	648	0	-
661 - 720	461	1	216.9
721 - 780	436	0	-
781 - 840	305	0	-
841 - 900	264	0	-
901 - 960	262	0	-
961 - 1020	175	0	-
1021 - 1080	154	0	-
1081 - 1140	213	0	-
1141 - 1200	131	0	-
1201 - 1260	86	1	1,162.8
1261 - 1320	72	0	-
1321 - 1380	52	0	-
1381 - 1440	40	0	-
1441 - 1500	47	1	2,127.7
1501 - 1560	40	1	2,500.0
1561 - 1620	25	0	-
1621 - 1680	41	0	-
1681 - 1740	22	0	-

1741 - 1800	27	1	3,703.7
1801 - 1860	28	1	3,571.4
Greater than 5 years	274	4	1,459.9
TOTAL	1,125,609	74	6.6

The following chart shows the mortality rates of detainees in ICE custody, adjusted for age of detainees.

Mortality Rate adjusted for Age of Detainee at Release from ICE Custody
Date Range: October 1, 2003 to May 11, 2008

Age at Release	Releases	Deaths	Death Rate per 100,000
0 - 18	22,704	0	-
19 - 25	324,346	8	2.5
26 - 30	248,375	8	3.2
31 - 35	201,189	8	4.0
36 - 40	139,538	7	5.0
41 - 45	89,593	5	5.6
46 - 50	52,491	9	17.1
51 - 55	27,061	9	33.3
56 - 60	12,048	7	58.1
61 - 65	4,852	5	103.1
66 - 70	1,868	3	160.6
71 - 75	621	4	644.1
76 - 80	210	0	-
81 - 85	67	1	1,492.5
86 - 90	11	0	-
91 - 95	3	0	-
96 - 100	5	0	-
Invalid DOB	627	0	-
TOTAL	1,125,609	74	6.6

Regarding your request for the morbidity and mortality rates of detainees in ICE custody, adjusted for age of the detainees, and for disease prevalence and incidences, the morbidity, disease prevalence rates, and disease incidence rates are not available. Therefore, neither morbidity nor mortality rates can be calculated simultaneously for these other factors.

Thank you once again for your interest in this matter. Please do not hesitate to contact me if you have additional questions. Chairman John Conyers will receive a separate, identical response.

Sincerely,

Julie L. Myers
Assistant Secretary

U.S. Department of Homeland Security
425 I Street, NW
Washington, DC 20536

U.S. Immigration
and Customs
Enforcement

SEP 1 1 2008

The Honorable Zoe Lofgren
Chairwoman
Subcommittee on Immigration, Citizenship, Refugees,
Border Security, and International Law
Committee on the Judiciary
U.S. House of Representatives
Washington, DC 20515

Dear Madam Chairwoman:

On behalf of Secretary Chertoff, thank you for your August 18, 2008, letter cosigned by House Judiciary Committee Chairman John Conyers, requesting an investigation of the circumstances surrounding the recent death of Hiu Lui Ng, while in the custody of U.S. Immigration and Customs Enforcement (ICE).

The death of any detainee in ICE's custody is regrettable. Department of Homeland Security (DHS) and ICE officials share your concerns regarding the death of Mr. Ng. Although ICE referred the circumstances surrounding the death of Mr. Ng to the DHS Office of the Inspector General (OIG), the OIG declined to investigate this matter. Therefore, ICE's Office of Professional Responsibility (OPR) has been instructed to conduct the investigation. You have my commitment that we will closely review all findings to ensure that appropriate procedures were followed and that the appropriate standard of care was met in this case. If we find any issues of concern, we will act on them promptly. Upon the conclusion of this investigation, ICE will be in contact with the Committee to arrange a briefing.

More broadly, I wanted to reiterate my commitment to detainee health care and overall care of those in ICE custody. ICE has significantly strengthened the oversight of its detention facilities. Part of our enhanced review process includes placing subject matter experts in selected facilities on a daily basis to monitor both the detention standards and detainees' quality of life. We have also contracted with subject matter experts to conduct annual inspections of all detention facilities housing ICE detainees. In order to provide additional oversight and assurance that facilities meet or exceed the National Detention Standards (NDS), ICE established the Detention Standards Compliance Unit at ICE Headquarters and also created the Detention Facilities Inspection Group, within OPR, as an independent oversight group that conducts targeted reviews in response to any allegations of non-compliance with the NDS.

In addition, ICE's Performance-Based National Detention Standards are currently being finalized and will be completed soon. We believe these revised standards represent a substantial step in our continuing efforts to provide a safe and secure environment for individuals in our custody. As I am sure you know, we have asked a number of nongovernmental organizations (NGOs) to comment on these standards. These NGOs include the American Civil Liberties Union, the American Bar Association, the American Immigration Lawyers Association, and Human Rights Watch. ICE also received comments on these standards from DHS's Offices of Civil Rights and Civil Liberties, Inspector General, and Health Affairs.

Your letter also reiterated your request of May 15, 2008, for materials related to the medical care of ICE detainees. Given the volume of materials being collected, we have provided you information as it has been available and provided you with additional information in my follow-up response of July 28, 2008, (enclosed). ICE's Office of Congressional Relations will contact the Committee staff about making the remaining materials available to the Committee within the next week.

I appreciate your interest in DHS, and in this particular matter. Please feel free to contact my office should you have additional questions. Chairman Conyers will receive a separate, identical response.

Sincerely,

Julie Myers

Julie L. Myers
Assistant Secretary

Enclosure

United States Department of State
Bureau of Consular Affairs

VISA BULLETIN

Number 1 Volume IX Washington, D.C.

IMMIGRANT NUMBERS FOR OCTOBER 2008

A. STATUTORY NUMBERS

1. This bulletin summarizes the availability of immigrant numbers during October. Consular officers are required to report to the Department of State documentarily qualified applicants for numerically limited visas; the Bureau of Citizenship and Immigration Services in the Department of Homeland Security reports applicants for adjustment of status. Allocations were made, to the extent possible under the numerical limitations, for the demand received by September 9th in the chronological order of the reported priority dates. If the demand could not be satisfied within the statutory or regulatory limits, the category or foreign state in which demand was excessive was deemed oversubscribed. The cut-off date for an oversubscribed category is the priority date of the first applicant who could not be reached within the numerical limits. Only applicants who have a priority date earlier than the cut-off date may be allotted a number. Immediately that it becomes necessary during the monthly allocation process to retrogress a cut-off date, supplemental requests for numbers will be honored only if the priority date falls within the new cut-off date.

2. Section 201 of the Immigration and Nationality Act (INA) sets an annual minimum family-sponsored preference limit of 226,000. The worldwide level for annual employment-based preference immigrants is at least 140,000. Section 202 prescribes that the per-country limit for preference immigrants is set at 7% of the total annual family-sponsored and employment-based preference limits, i.e., 25,620. The dependent area limit is set at 2%, or 7,320.

3. Section 203 of the INA prescribes preference classes for allotment of immigrant visas as follows:

FAMILY-SPONSORED PREFERENCES

First: Unmarried Sons and Daughters of Citizens: 23,400 plus any numbers not required for fourth preference.

Second: Spouses and Children, and Unmarried Sons and Daughters of Permanent Residents: 114,200, plus the number (if any) by which the worldwide family preference level exceeds 226,000, and any unused first preference numbers:

A. Spouses and Children: 77% of the overall second preference limitation, of which 75% are exempt from the per-country limit;

B. Unmarried Sons and Daughters (21 years of age or older): 23% of the overall second preference limitation.

Third: Married Sons and Daughters of Citizens: 23,400, plus any numbers not required by first and second preferences.

Fourth: Brothers and Sisters of Adult Citizens: 65,000, plus any numbers not required by first three preferences.

EMPLOYMENT-BASED PREFERENCES

First: Priority Workers: 28.6% of the worldwide employment-based preference level, plus any numbers not required for fourth and fifth preferences.

Second: Members of the Professions Holding Advanced Degrees or Persons of Exceptional Ability: 28.6% of the worldwide employment-based preference level, plus any numbers not required by first preference.

Third: Skilled Workers, Professionals, and Other Workers: 28.6% of the worldwide level, plus any numbers not required by first and second preferences, not more than 10,000 of which to "Other Workers".

Fourth: Certain Special Immigrants: 7.1% of the worldwide level.

Fifth: Employment Creation: 7.1% of the worldwide level, not less than 3,000 of which reserved for investors in a targeted rural or high-unemployment area, and 3,000 set aside for investors in regional centers by Sec. 610 of P.L. 102-395.

4. INA Section 203(e) provides that family-sponsored and employment-based preference visas be issued to eligible immigrants in the order in which a petition in behalf of each has been filed. Section 203(d) provides that spouses and children of preference immigrants are entitled to the same status, and the same order of consideration, if accompanying or following to join the principal. The visa prorating provisions of Section 202(e) apply to allocations for a foreign state or dependent area when visa demand exceeds the per-country limit. These provisions apply at present to the following oversubscribed chargeability areas: CHINA-mainland born, INDIA, MEXICO, and PHILIPPINES.

5. On the chart below, the listing of a date for any class indicates that the class is oversubscribed (see paragraph 1); "C" means current, i.e., numbers are available for all qualified applicants; and "U" means unavailable, i.e., no numbers are available. (NOTE: Numbers are available only for applicants whose priority date is earlier than the cut-off date listed below.)

	All Chargeability Areas Except Those Listed	CHINA-mainland born	INDIA	MEXICO	PHILIPPINES
Family					
1st	15APR02	15APR02	15APR02	08SEP92	01APR93
2A	01JAN04	01JAN04	01JAN04	01MAY01	01JAN04
2B	15DEC99	15DEC99	15DEC99	22APR92	08MAY97
3rd	22JUN00	22JUN00	22JUN00	15SEP92	01MAY91
4th	22OCT97	01MAY97	22MAY97	15JAN95	08MAR86

*NOTE: For October, 2A numbers EXEMPT from per-country limit are available to applicants from all countries with priority dates earlier than 01MAY01. 2A numbers SUBJECT to per-country limit are available to applicants chargeable to all countries EXCEPT MEXICO with priority dates beginning 01MAY01 and earlier than 01JAN04. (All 2A numbers provided for MEXICO are exempt from the per-country limit; there are no 2A numbers for MEXICO subject to per-country limit.)

	All Chargeability Areas Except Those Listed	CHINA-mainland born	INDIA	MEXICO	PHILIPPINES
Employment-Based					
1st	C	C	C	C	C
2nd	C	01APR04	01APR03	C	C
3rd	01JAN05	01OCT01	01JUL01	01JUL02	01JAN05
Other Workers	01JAN03	01JAN03	01JAN03	01JAN03	01JAN03
4th	C	C	C	C	C
Certain Religious Workers	C	C	C	C	C
5th	C	C	C	C	C
Targeted Employment Areas/ Regional Centers	C	C	C	C	C

The Department of State has available a recorded message with visa availability information which can be heard at: (area code 202) 663-1541. This recording will be updated in the middle of each month with information on cut-off dates for the following month.

Employment Third Preference Other Workers Category: Section 203(e) of the NACARA, as amended by Section 1(e) of Pub. L. 105-139, provides that once the Employment Third Preference Other Worker (EW) cut-off date has reached the priority date of the latest EW petition approved prior to November 19, 1997, the 10,000 EW numbers available for a fiscal year are to be reduced by up to 5,000 annually beginning in the following fiscal year. This reduction is to be made for as long as necessary to offset adjustments under the NACARA program. Since the EW cut-off date reached November 19, 1997 during Fiscal Year 2001, the reduction in the EW annual limit to 5,000 began in Fiscal Year 2002.

B. DIVERSITY IMMIGRANT (DV) CATEGORY

Section 203(c) of the Immigration and Nationality Act provides a maximum of up to 55,000 immigrant visas each fiscal year to permit immigration opportunities for persons from countries other than the principal sources of current immigration to the United States. The Nicaraguan and Central American Relief Act (NACARA) passed by Congress in November 1997 stipulates that beginning with DV-99, and for as long as necessary, up to 5,000 of the 55,000 annually-allocated diversity visas will be made available for use under the NACARA program. This reduction has resulted in the DV-2009 annual limit being reduced to 50,000. DV visas are divided among six geographic regions. No one country can receive more than seven percent of the available diversity visas in any one year.

For October, immigrant numbers in the DV category are available to qualified DV-2009 applicants chargeable to all regions/eligible countries as follows. When an allocation cut-off number is shown, visas are available only for applicants with DV regional lottery rank numbers BELOW the specified allocation cut-off number:

Region	All DV Chargeability Areas Except Those Listed Separately		
AFRICA	6,900	Except:	Egypt 3,100 Ethiopia 3,600 Nigeria 3,350
ASIA	2,900		
EUROPE	6,600		
NORTH AMERICA (BAHAMAS)	2		
OCEANIA	200		
SOUTH AMERICA, and the CARIBBEAN	375		

Entitlement to immigrant status in the DV category lasts only through the end of the fiscal (visa) year for which the applicant is selected in the lottery. The year of entitlement for all applicants registered for the DV-2009 program ends as of September 30, 2009. DV visas may not be issued to DV-2009 applicants after that date. Similarly, spouses and children accompanying or following to join DV-2009 principals are only entitled to derivative DV status until September 30, 2009. DV visa availability through the very end of FY-2009 cannot be taken for granted. Numbers could be exhausted prior to September 30.

C. ADVANCE NOTIFICATION OF THE DIVERSITY (DV) IMMIGRANT CATEGORY RANK CUT-OFFS WHICH WILL APPLY IN NOVEMBER

For November, immigrant numbers in the DV category are available to qualified DV-2009 applicants chargeable to all regions/eligible countries as follows. When an allocation cut-off number is shown, visas are available only for applicants with DV regional lottery rank numbers BELOW the specified allocation cut-off number:

Region	All DV Chargeability Areas Except Those Listed Separately		
AFRICA	12,500	Except:	Egypt 5,900 Ethiopia 6,300 Nigeria 6,000
ASIA	5,300		
EUROPE	11,000		
NORTH AMERICA (BAHAMAS)	3		
OCEANIA	325		
SOUTH AMERICA, and the CARIBBEAN	550		

D. MEXICO F2A VISA AVAILABILITY FOR OCTOBER

Heavy demand for numbers in the Mexico F2A category has required the establishment of a cut-off date which is earlier than that which applied in June (after which they became "unavailable" for the remainder of FY-2008). The Mexico F2A cut-off date for October will be 01MAY01. Forward movement during the first quarter of the new fiscal year is likely to be limited.

E. EMPLOYMENT VISA AVAILABILITY

Item E of the May 2008 Visa Bulletin (number 116, volume VIII) indicated that many Employment cut-off dates had been advancing very rapidly, based on indications that the Citizenship and Immigration Services (CIS) would need to review a significantly larger pool of applicants than there were numbers available in order to maximize number use under the FY-2008 annual limits. That item also indicated that if the CIS projections proved to be incorrect, it would be necessary to adjust the cut-off dates during the final quarter of FY-2008. The CIS estimates have proven to be very high resulting in: 1) the "unavailability" of all Employment Third preference categories beginning in July, 2) the "unavailability" of numbers for China and India Employment Second preference adjustment of status cases during September, and 3) the establishment of many October Employment cut-off dates which are earlier than those which applied during FY-2008.

Little if any forward movement of the cut-off dates in most Employment categories is likely until the extent of the CIS backlog of old priority dates can be determined. It is estimated that the FY-2009 Employment-based annual limit will be very close to the 140,000 minimum.

F. DIVERSITY VISA LOTTERY PROGRAM REGISTRATION PERIOD

The Diversity Visa (DV) lottery will open for DV-2010 entries on October 2, 2008 (noon, EST) and end on December 1, 2008 (noon, EST). Applicants may access the electronic Diversity Visa entry form at www.dvlottery.state.gov during the registration period. Instructions and additional information will be available at this site by mid September.

For DV-2010, Russia has been added back to the list of eligible countries. Kosovo was also added to the list of eligible countries. No countries have been removed from the list of eligible countries for DV-2010 program.

G. OBTAINING THE MONTHLY VISA BULLETIN

The Department of State's Bureau of Consular Affairs offers the monthly "Visa Bulletin" on the INTERNET'S WORLDWIDE WEB. The INTERNET Web address to access the Bulletin is:

http://travel.state.gov

From the home page, select the VISA section which contains the Visa Bulletin.

To be placed on the Department of State's E-mail subscription list for the "Visa Bulletin", please send an E-mail to the following E-mail address:

listserv@calist.state.gov

and in the message body type:
Subscribe Visa-Bulletin *First name/Last name*
(example: Subscribe Visa-Bulletin Sally Doe)

To be removed from the Department of State's E-mail subscription list for the "Visa Bulletin", send an e-mail message to the following E-mail address:

listserv@calist.state.gov

and in the message body type: **Signoff Visa-Bulletin**

The Department of State also has available a recorded message with visa cut-off dates which can be heard at: (area code 202) 663-1541. The recording is normally updated by the middle of each month with information on cut-off dates for the following month.

Readers may submit questions regarding Visa Bulletin related items by E-mail at the following address:

VISABULLETIN@STATE.GOV

(This address cannot be used to subscribe to the Visa Bulletin.)

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CA/VO:September 9, 2008

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